

DR. R. J. WILLIAMS

2357 CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLERSLIE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ETHEL Middle U. Last ALBRIGHT				4. DATE OF DEATH Month MARCH Day 31 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 16, 1893	
9. AGE (In years lost birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) CONNELLSVILLE, PA.	
13. FATHER'S NAME THOMAS GAUS				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cert Lab Corp 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Failure DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/7/54 , 19___, to 3/31/57 , 19___, that I last saw the deceased alive on 3/31/57 , 19___, and that death occurred at 4:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 3/31/57							
ACTUAL SIGNATURE R. J. Williams M.D.				PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		4-2-57		Hyndman Cemetery Hyndman, Pa		Pa	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Tigner				ADDRESS Hyndman, Pa		24a. REC'D BY REGISTRAR April 1, 1957	
						24b. REGISTRAR'S SIGNATURE A.R. Tandy, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2358 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02372

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 15 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edgar Middle John Last Allen		4. DATE OF DEATH Month March Day 12 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19-1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Shipping Clerk - Kelley-Springfield-Alaska, W.Va.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel Allen	
14. MOTHER'S MAIDEN NAME Alice Neff		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 219-03-8812		17. INFORMANT (wife) Evelyn M. Allen, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary sclerosis with Angina syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arteriosclerosis with hypertention		INTERVAL BETWEEN ONSET AND DEATH sudden about 4 years ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 0 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED March 12-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 14, 1957	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Kight Funeral Home, Cumberland, Maryland.		24a. REC'D BY REGISTRAR March 13, 1957	
24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 15 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 13 Fil-G213 4-5-57 et

02373

CERTIFICATE OF DEATH

2432

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rt 1. Frostburg</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rt 1. Frostburg</u>		<u>"Rural"</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Sarah</u>		(Middle) <u>Ann</u>		(Last) <u>Amstutz</u>		(Month) <u>March</u> (Day) <u>21</u> (Year) <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>August 16, 1898</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Garrett County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Mary Fazenbaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Leroy Dye</u> <u>Barton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs -</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Chronic Cardiovascular Disease</u>				<u>Years -</u>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 2, 19 57</u> , to <u>March 21, 19 57</u> , that I last saw the deceased alive on <u>March 20, 19 57</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John B. Davis</u>				ADDRESS (Street, city, town, state) <u>M.D. 2 Broadway, Frostburg, Md.</u>		DATE SIGNED <u>3/21/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/24/57</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Moscow, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>3-24-57</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy K. Rose</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u>		ADDRESS <u>Lonaconing, Md.</u>	

4233

MAINTAINING STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

2133

NAME OF DECEASED J. A. ROBERTSON		SEX Male		AGE 65	
DATE OF DEATH April 1, 1937		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		OCCUPATION Retired	
EDUCATION High School		RELIGION Roman Catholic		MARITAL STATUS Married	
BIRTH DATE March 1, 1872		BIRTH PLACE Maryland		PARENTS J. A. Robertson, Father Mary A. Robertson, Mother	
SIGNED BY J. A. Robertson		WITNESSED BY J. A. Robertson		DATE April 1, 1937	

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APR 1 1937

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42422 J. A. Robertson
George A. Robertson

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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 22		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS 121 S. Water St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DELLA		First HOTT		Middle ANDERSON	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8 - 11 - 1888		9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Carlos, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Hott	
14. MOTHER'S MAIDEN NAME Mary Miller		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-14-5956	
17. INFORMANT 3 Taylor St., Mrs. Bray Thompson, Frostburg, Md. (Dght)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardiovascular disease DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Has Cap of nose probably metastasis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from March 19, 1957 to March 31, 1957 , that I last saw the deceased alive on March 31, 1957 , and that death occurred at 12:00 A.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE John B. Davis, M.D.		ADDRESS (Street, city or town, state) 2 Broadway Frostburg, Md.		DATE SIGNED 3/8/57	
PHYSICIAN'S NAME (Type) John B. Davis, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/57	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg, Md.		22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE Beulah H. Montross	
24. REC'D BY REGISTRAR 4-2-57		25. REGISTRAR'S SIGNATURE Miss M. H. H. H.		26. HAFER FUNERAL HOME	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore, Md.

DATE OF DEATH

MARRIAGE

PLACE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

OTHER

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

OTHER

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

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CAUSE OF DEATH

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INTERMEDIATE

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CAUSE OF DEATH

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INTERMEDIATE

FINAL

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CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

OTHER

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BUREAU V. S.

APR 11 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
24114 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02374

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47x-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>at the Miners Hospital</u>				d. STREET ADDRESS <u>1752 Kilbourne Place, N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Michael</u> Last <u>Etter Anderson</u>				4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>19 57</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 8-1956</u>		
9. AGE (In years last birthday) <u>1 yrs.</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>8</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dale Phenicie</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Catherine Etter</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Miners Hospital records</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured cervical vertebrae (broken neck)</u> <u>824X</u> DUE TO Intracranial hemorrhage due to a fractured skull, right tempo-parietal region. (auto accident) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver lost control of car, occupants thrown out.</u>					
20c. TIME OF INJURY Month, Day, Year <u>5.10 p.m. 3-15 19 57</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, lot, etc., or town, factory, street, office bldg., etc.) <u>About 20 miles west of Frostburg, Allegany, Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>H.V. Deming, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 16-1957</u>				DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-20-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln, Babylon</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George C. Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Pearl H. Mettenly, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>3-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Harry H. Roe</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

2002

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02375

2416 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>		LENGTH OF STAY (in this place) <u>33 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lonaconing</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>Water Station Run</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Thomas Arnold</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 20, 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 22, 1892</u>		9. AGE last birthday <u>64</u> yrs.	10. IF UNDER 1 Year (Months) (Days) (Hours) (Min.) <u>20</u> <u>19</u> <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Arnold</u>				14. MOTHER'S MAIDEN NAME <u>Elise Ritchie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-05-2941</u>		17. INFORMANT & ADDRESS <u>James Arnold Lonaconing, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION "Brother"		INTERVAL BETWEEN ONSET AND DEATH	
153x IMMEDIATE CAUSE (A) <u>Metastatic Carcinoma liver</u>						<u>6 mos +</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of descending colon</u>						<u>"</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 27, 19 56</u> , to <u>March 20, 19 57</u> , that I last saw the deceased alive on <u>Mar 20, 19 57</u> and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Leslie R. Miles Jr.</u>				ADDRESS (Street, city, town, state) <u>Lonaconing Md</u>		DATE SIGNED <u>3-22-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/23/57</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Lonaconing, Md.</u>	
24. REC'D BY REGISTRAR DATE: <u>3-24-57</u>		REGISTRAR'S SIGNATURE <u>Wm. Stanley H. R.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u>		ADDRESS <u>Lonaconing, Md.</u>	

BUREAU V. S.

APR 3 1937

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 32

1937

2011-10-10

2359

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b 16 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital, Memorial Ave.		1. d. STREET ADDRESS 426 N. Centre St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mr. Karl Middle D. Last Bachman		4. DATE OF DEATH Month March Day 19 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/5/85
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician - Retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry A. Bachman		14. MOTHER'S MAIDEN NAME Kathryn Dehler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 705 09 8678	
17. INFORMANT Memorial Hospital, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Renal Failure DUE TO adenocarcinoma Rectum Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause last. DUE TO arteriosclerotic Heart Disease (b) arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hours 1 year 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11:00 am , 19 45 , to 19:45 , that I last saw the deceased alive on 19:45 , and that death occurred at 8:10 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED W. Alfred Vance M.D. Cumberland, Md. 19:45	
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/1957	
22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR March 21, 1957		24b. REGISTRAR'S SIGNATURE W. H. Kight, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MAR 22 1957

RECEIVED

2417 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 61 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 2 Mt. Savage			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Miners Hoapital				d. STREET ADDRESS / Calla Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edgar Middle Beaver Last Beaver				4. DATE OF DEATH Month March Day 14 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26-1895		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 61 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hostler		10b. KIND OF BUSINESS OR INDUSTRY W.Md. R.Ry.		11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Beaver				14. MOTHER'S MAIDEN NAME Mary Krause			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1 712-14-2008		17. INFORMANT Address (wife) Edna Beaver, Mt Savage, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis (c) Diabetes mellitus							INTERVAL BETWEEN ONSET AND DEATH sudden ? about 3 Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 0 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 14-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-17-57		22c. NAME OF CEMETERY OR CREMATORY ST. GEORGE		22d. LOCATION (City, town, or county) (State) MT. SAVAGE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Hurst				24a. REC'D BY REGISTRAR DATE 3-17-57		24b. REGISTRAR'S SIGNATURE Dur Nancy H. Roe	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

MAR 21 1957

RECEIVED

2360

CERTIFICATE OF DEATH

02378

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PENNSYLVANIA b. COUNTY BEDFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 7 HRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL, MEMORIAL AVE.				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) MR. WARREN First H. BELTZ Middle LAST				4. DATE OF DEATH MARCH 26 19 57 Month Day Year			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 21, 1877		9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) MANNS CHOICE, PA.	
13. FATHER'S NAME ABRAM BELTZ				14. MOTHER'S MAIDEN NAME JULIA TURNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic vascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Hypertrophy of Prostate						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3. 26 , 19 57 , to 3. 26 , 19 57 , that I last saw the deceased alive on 3. 26 , 19 57 , and that death occurred at 6:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland, Md		DATE SIGNED 3. 28. 57	
PHYSICIAN'S NAME (Type) W. F. WILLIAMS, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 29, 1957		22c. NAME OF CEMETERY OR CREMATORY Schellsburg Cemetery		22d. LOCATION (City, town, or county) (State) Schellsburg, Pennsylvania.	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Zeigler, Hyndman, Pennsylvania.				24a. REC'D BY REGISTRAR March 28, 1957			
				24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. SMITH		M		45		JAN 15 1912	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
BALTIMORE		MD		MD		USA	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
SELF EMPLOYED		HIGH SCHOOL		METHODIST		MARRIED	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
HEART DISEASE		NATURAL		HOME		MAY 10 1957	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
MAY 10 1957		HOME		BALTIMORE		MD	
NAME OF HOSPITAL		NAME OF PHYSICIAN		NAME OF REGISTRAR		NAME OF WITNESS	
BALTIMORE HOSPITAL		J. H. SMITH		J. H. SMITH		J. H. SMITH	

RECEIVED
MAR 29 1957
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2361 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02379

Reg. Dist. No. **4**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE W.Va. b. COUNTY Hampshire			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN lb 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Romney 85X-3			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First John Middle Charles Last Blackburn				4. DATE OF DEATH Month March Day 2 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18-1907		9. AGE (in years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor- Romney Grade School		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Hardy Co. W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jess Blackburn				14. MOTHER'S MAIDEN NAME Carrie Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 236-03-6761		17. INFORMANT Address Memorial Hospital records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Delirium tremens DUE TO Acute alcoholism also Conditions, if any, which gave rise to immediate cause (b) (c) 1st.2nd.&3rd.degree burns about 15 % of night side of body DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 916.8							INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Explosion		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) gasoline lantern. Glass gasoline container in coat pocket, leaked on hot					
20c. TIME OF INJURY Month, Day, Year 7.30 p.m. Feb 26 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Country-near-Romney Hampshire W.Va.		20f. (City or town) (County) (State) 		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 2-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/1957	22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Romney W Va		
23. FUNERAL DIRECTOR'S SIGNATURE Meryl Combs, Romney, W Va		ADDRESS 		24a. REC'D BY REGISTRAR March 3, 1957		24b. REGISTRAR'S SIGNATURE W.R. Hantz, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

288 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 6 1957

RECEIVED

2362 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Cumberland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 73 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at the Memorial Hospital		d. STREET ADDRESS 417 Springdale St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mathilda Middle Agnes Last Blaine		4. DATE OF DEATH March 22 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30-1883
9. AGE (in years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & domestic		10b. KIND OF BUSINESS OR INDUSTRY Town Creek, Md. (rural)	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ross Crabtree		14. MOTHER'S MAIDEN NAME Agnes (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-26-6724	
17. INFORMANT (daughter) Mrs. Mary Layton, Cumberland, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock, contusion of brain, fractured pelvis, 812x DUE TO also had a fracture of right clavical and Conditions, if any, which gave rise to immediate cause (b) (c) Comminuted fracture above right ankle. (Auto Accident. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stepped off of curb & hit by a passing auto.	
20c. TIME OF INJURY Month, Day, Year 8.25 p.m. March 22/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Virginia Ave		20f. (City or town) (County) (State) Cumberland Allegany Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 23-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 25, 1957	22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.		24a. REC'D BY REGISTRAR March 23, 1957	
		24b. REGISTRAR'S SIGNATURE W.R. Kantz, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

115 35M
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTY	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		WIDOWED	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY		STATE		COUNTY		DEPARTMENT		DIVISION	
SIGNATURE OF WITNESS		DATE		TIME		PLACE		CITY		STATE		COUNTY		DEPARTMENT		DIVISION	
SIGNATURE OF JURY		DATE		TIME		PLACE		CITY		STATE		COUNTY		DEPARTMENT		DIVISION	
SIGNATURE OF JUDGE		DATE		TIME		PLACE		CITY		STATE		COUNTY		DEPARTMENT		DIVISION	
SIGNATURE OF CLERK		DATE		TIME		PLACE		CITY		STATE		COUNTY		DEPARTMENT		DIVISION	
SIGNATURE OF ATTORNEY		DATE		TIME		PLACE		CITY		STATE		COUNTY		DEPARTMENT		DIVISION	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE		CITY		STATE		COUNTY		DEPARTMENT		DIVISION	
SIGNATURE OF CORONER		DATE		TIME		PLACE		CITY		STATE		COUNTY		DEPARTMENT		DIVISION	
SIGNATURE OF JURY		DATE		TIME		PLACE		CITY		STATE		COUNTY		DEPARTMENT		DIVISION	
SIGNATURE OF JUDGE		DATE		TIME		PLACE		CITY		STATE		COUNTY		DEPARTMENT		DIVISION	
SIGNATURE OF CLERK		DATE		TIME		PLACE		CITY		STATE		COUNTY		DEPARTMENT		DIVISION	
SIGNATURE OF ATTORNEY		DATE		TIME		PLACE		CITY		STATE		COUNTY		DEPARTMENT		DIVISION	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE		CITY		STATE		COUNTY		DEPARTMENT		DIVISION	
SIGNATURE OF CORONER		DATE		TIME		PLACE		CITY		STATE		COUNTY		DEPARTMENT		DIVISION	

RECEIVED
MAR 27 1957
BUREAU K. A.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02381

CERTIFICATE OF DEATH

Reg. Dist. No. 16

2433

1. PLACE OF DEATH COUNTY <u>ALLEGANY</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ELLERSLIE</u> LENGTH OF STAY (in this place) <u>LIFE</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ELLERSLIE</u> STREET ADDRESS <u>1</u> (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>FRANK</u> (Middle) <u>R</u> (Last) <u>BOHN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 11, 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>August 27, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSPECTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>KEELY SPRINGFIELD ELLERSLIE, MD</u>	9. AGE last birthday <u>63</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALBERT BOHN</u>		14. MOTHER'S MAIDEN NAME <u>RENNIE NORRIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WORLD WAR I</u>		16. SOCIAL SECURITY NO. <u>214-05-9914</u>	
17. INFORMANT & ADDRESS <u>Mrs. RUBY RALEY, ELLERSLIE, MD</u>		18. MEDICAL CERTIFICATION	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 430.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) STATING UNDERLYING CAUSE LAST, DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 1, 1950</u> , to <u>Mar 11, 1957</u> , that I last saw the deceased alive on <u>Mar 11, 1957</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>John L. Topper, M.D.</u>		ADDRESS (Street, city, town, state) <u>Hyndman, PA</u>	
DATE SIGNED <u>3-12-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MARCH 14 1957</u>	
NAME OF CEMETERY OR CREMATORY <u>Madley Cemetery</u>		LOCATION (City, town, or county) <u>Buffalo Mills, PA</u>	
24. REC'D BY REGISTRAR <u>Lloyd Wolfe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HARVEY H. LEIGLER</u>	
DATE <u>March 13, 1957</u>		ADDRESS <u>Hyndman, PA</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A153 10M

2363 CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>613 Louisiana Ave</u>		d. STREET ADDRESS <u>613 Louisiana Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Claude</u> Middle <u>M</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 6 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BORR</u>	
11. BIRTHPLACE (State or foreign country) <u>Belfonte Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME (Unknown) <u>Brown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-094028</u>	
17. INFORMANT <u>Mrs Rhea K Brown</u>		Address <u>Cumberland Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-3-57</u> to <u>3-24-57</u> , that I last saw the deceased alive on <u>2-15-57</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. F. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>Cumberland Md</u> DATE SIGNED <u>3-25-57</u>	
PHYSICIAN'S NAME (Type) <u>Wm. F. Williams, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 26/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brook Hill Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Wright</u>		ADDRESS <u>Cumberland Md</u>	
24a. REC'D BY REGISTRAR <u>March 26, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF FUNERAL HOME</p>		<p>18. SIGNATURE OF CHURCH OFFICIAL</p>	
<p>19. SIGNATURE OF CEMETERY OFFICIAL</p>		<p>20. SIGNATURE OF INTERVIEWER</p>	
<p>21. SIGNATURE OF INTERVIEWER</p>		<p>22. SIGNATURE OF INTERVIEWER</p>	
<p>23. SIGNATURE OF INTERVIEWER</p>		<p>24. SIGNATURE OF INTERVIEWER</p>	
<p>25. SIGNATURE OF INTERVIEWER</p>		<p>26. SIGNATURE OF INTERVIEWER</p>	
<p>27. SIGNATURE OF INTERVIEWER</p>		<p>28. SIGNATURE OF INTERVIEWER</p>	
<p>29. SIGNATURE OF INTERVIEWER</p>		<p>30. SIGNATURE OF INTERVIEWER</p>	
<p>31. SIGNATURE OF INTERVIEWER</p>		<p>32. SIGNATURE OF INTERVIEWER</p>	
<p>33. SIGNATURE OF INTERVIEWER</p>		<p>34. SIGNATURE OF INTERVIEWER</p>	
<p>35. SIGNATURE OF INTERVIEWER</p>		<p>36. SIGNATURE OF INTERVIEWER</p>	
<p>37. SIGNATURE OF INTERVIEWER</p>		<p>38. SIGNATURE OF INTERVIEWER</p>	
<p>39. SIGNATURE OF INTERVIEWER</p>		<p>40. SIGNATURE OF INTERVIEWER</p>	
<p>41. SIGNATURE OF INTERVIEWER</p>		<p>42. SIGNATURE OF INTERVIEWER</p>	
<p>43. SIGNATURE OF INTERVIEWER</p>		<p>44. SIGNATURE OF INTERVIEWER</p>	
<p>45. SIGNATURE OF INTERVIEWER</p>		<p>46. SIGNATURE OF INTERVIEWER</p>	
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<p>55. SIGNATURE OF INTERVIEWER</p>		<p>56. SIGNATURE OF INTERVIEWER</p>	
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<p>59. SIGNATURE OF INTERVIEWER</p>		<p>60. SIGNATURE OF INTERVIEWER</p>	
<p>61. SIGNATURE OF INTERVIEWER</p>		<p>62. SIGNATURE OF INTERVIEWER</p>	
<p>63. SIGNATURE OF INTERVIEWER</p>		<p>64. SIGNATURE OF INTERVIEWER</p>	
<p>65. SIGNATURE OF INTERVIEWER</p>		<p>66. SIGNATURE OF INTERVIEWER</p>	
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<p>69. SIGNATURE OF INTERVIEWER</p>		<p>70. SIGNATURE OF INTERVIEWER</p>	
<p>71. SIGNATURE OF INTERVIEWER</p>		<p>72. SIGNATURE OF INTERVIEWER</p>	
<p>73. SIGNATURE OF INTERVIEWER</p>		<p>74. SIGNATURE OF INTERVIEWER</p>	
<p>75. SIGNATURE OF INTERVIEWER</p>		<p>76. SIGNATURE OF INTERVIEWER</p>	
<p>77. SIGNATURE OF INTERVIEWER</p>		<p>78. SIGNATURE OF INTERVIEWER</p>	
<p>79. SIGNATURE OF INTERVIEWER</p>		<p>80. SIGNATURE OF INTERVIEWER</p>	
<p>81. SIGNATURE OF INTERVIEWER</p>		<p>82. SIGNATURE OF INTERVIEWER</p>	
<p>83. SIGNATURE OF INTERVIEWER</p>		<p>84. SIGNATURE OF INTERVIEWER</p>	
<p>85. SIGNATURE OF INTERVIEWER</p>		<p>86. SIGNATURE OF INTERVIEWER</p>	
<p>87. SIGNATURE OF INTERVIEWER</p>		<p>88. SIGNATURE OF INTERVIEWER</p>	
<p>89. SIGNATURE OF INTERVIEWER</p>		<p>90. SIGNATURE OF INTERVIEWER</p>	
<p>91. SIGNATURE OF INTERVIEWER</p>		<p>92. SIGNATURE OF INTERVIEWER</p>	
<p>93. SIGNATURE OF INTERVIEWER</p>		<p>94. SIGNATURE OF INTERVIEWER</p>	
<p>95. SIGNATURE OF INTERVIEWER</p>		<p>96. SIGNATURE OF INTERVIEWER</p>	
<p>97. SIGNATURE OF INTERVIEWER</p>		<p>98. SIGNATURE OF INTERVIEWER</p>	
<p>99. SIGNATURE OF INTERVIEWER</p>		<p>100. SIGNATURE OF INTERVIEWER</p>	

BUREAU A. S.

MAR 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File-pages 1 and 2 with the registrar prior to burial or cremation, or removal.

VS. A15ME(5)
SM 9/55

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

236

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02383

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 1726 Fayette St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John First J. Middle Bucklew Last		4. DATE OF DEATH Month March Day 27 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18-1895
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	
11. BIRTHPLACE (State or foreign country) Morefield, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Bucklew		14. MOTHER'S MAIDEN NAME Emma S. Pope	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) yes W.W.I		16. SOCIAL SECURITY NO. 217-10-4971	
17. INFORMANT (sister) Mrs. L.F. Starnes, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (b) ? (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.		DEPUTY MEDICAL EXAMINER March 28-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Mar 30, 1957	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumb. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stern Inc.		ADDRESS Cumb. Md.	
24a. REC'D BY REGISTRAR March 28, 1957		24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

INDICATE EXAMINER'S CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

BUREAU V. 8

MAR 29 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 21 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grover Middle Cleveland Last Butler		4. DATE OF DEATH Month March Day 26 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/1896
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Attendant		10b. KIND OF BUSINESS OR INDUSTRY Algonquin Hotel	
11. BIRTHPLACE (State or foreign country) Mineral County, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harvey Butler		14. MOTHER'S MAIDEN NAME Marguerite Margaret N. Trenter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Clara B. Butler, Cumberland, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 420.0 DUE TO Left + Right, due to Conditions, if any, which gave rise to immediate cause (b) DUE TO Arteriosclerotic Heart Disease lying cause last. (c) Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/25 , 19 57 , to 3/26 , 19 57 , that I last saw the deceased alive on 3/25 , 19 57 , and that death occurred at 5:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 59 Green St DATE SIGNED 3/26/57 ACTUAL SIGNATURE S. G. WEISMAN M.D. S. G. WEISMAN M.D., Cumberland, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 29, 1957	
22c. NAME OF CEMETERY OR CREMATORY Queen's Point Cemetery		22d. LOCATION (City, town, or county) (State) Keyser, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE N. L. Rogers Funeral Home, Keyser, West Virginia		24a. REC'D BY REGISTRAR March 27, 1957	
24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.			

1
24
Within corporate limits
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02385

DR. HIMMELWRIGHT • 2366 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 120 W. THIRD STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AUGUSTA Middle CAPORALE Last		4. DATE OF DEATH Month MARCH Day 2 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 28, 1878
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY BAKERY OPERATOR	
11. BIRTHPLACE (State or foreign country) ITALY Cheiti		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FELIX CAPORALE		14. MOTHER'S MAIDEN NAME Tiberia unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-32-3445	
(If yes, give war or dates of service)		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO 480.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Lymphoid Leukemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 1957, to March , 1957, that I last saw the deceased alive on March 2 , 1957, and that death occurred at 1:02 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE DR. O. HIMMELWRIGHT		ADDRESS (Street, city or town, state) DATE SIGNED 133 Virginia Ave, Cumberland, Md 3/2/57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-5-57	
22c. NAME OF CEMETERY OR CREMATORY St. Patrick Cem		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR March 15, 1957		24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	

BUREAU V. 3

MAR 7 1957

RECEIVED

2434 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. F. D. 1-Oldtown		c. LENGTH OF STAY IN 1b 50yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. F. D. Oldtown, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle N. Carder Last		4. DATE OF DEATH Month Mar. Day 10 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1886
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Equipment Op.		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Oldtown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harley Carder		14. MOTHER'S MAIDEN NAME Loretta Brant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 211-07-6370	
17. INFORMANT William F. Carder, La Vale, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerosis of the heart 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 year			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to 3-10-1957 that I last saw the deceased alive on January 1957 , and that death occurred at 3 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James T. Johnson Jr. M.D.		ADDRESS (Street, city or town, state) Cumtuck, Md. DATE SIGNED 3-11-57	
PHYSICIAN'S NAME (Type) James T. Johnson Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-13-57	
22c. NAME OF CEMETERY OR CREMATORY Oldtown Cemetery		22d. LOCATION (City, town, or county) (State) Oldtown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Oldtown, Md.		24. REC'D BY REGISTRAR March 13, 1957	
		24b. REGISTRAR'S SIGNATURE Fay Duckworth	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES E. O'CONNOR		M		45		JAN 15 1912		BALTIMORE		MD		USA			
MARRIAGE		SINGLE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
JAN 15 1912		BALTIMORE		MD		USA									
OCCUPATION		PROFESSION		INDUSTRY		BUSINESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
JAN 15 1912		BALTIMORE		MD		USA									
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
JAN 15 1912		BALTIMORE		MD		USA									
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
JAN 15 1912		BALTIMORE		MD		USA									

BUREAU V. S.

MAR 18 1957

RECEIVED

2367 CERTIFICATE OF DEATH

Reg. Dist. No.

4

Within corporate limits

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 47 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				e. STREET ADDRESS 509 Caroline Street			
3. NAME OF DECEASED (Type or print) First Mary Middle Helena Last Carney				4. DATE OF DEATH Month Mar. Day 21 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1873	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Keenan				14. MOTHER'S MAIDEN NAME Margaret Ann Mc Bride			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. J. Joseph Carney, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 2 , 19 57 , to Mar. 21 , 19 57 , that I last saw the deceased alive on Mar. 21 , 19 57 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 105 S. Centre St. DATE SIGNED 3-22-57							
ACTUAL SIGNATURE C.C. Zimmermann M.D.				PHYSICIAN'S NAME (Type) C.C. Zimmermann, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-25, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24. REC'D BY REGISTRAR March 25, 1957			
				24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAR 27 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2368 CERTIFICATE OF DEATH

Reg. Dist. No.

02388

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 50 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.				d. STREET ADDRESS 1308 CUMBERLAND ST.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PATRICK Middle J. Last CARROLL				4. DATE OF DEATH Month MARCH Day 14 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 25, 1892		9. AGE (In years lost birthday) yrs. 64	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Supervisor of the Unemployment Comp. Dept.				10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES P. CARROLL				14. MOTHER'S MAIDEN NAME MARGARET KENNEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) War I		16. SOCIAL SECURITY NO. 220-03-7704		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Nov 19 1957							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-10-56 to 3-14-57 , that I last saw the deceased alive on 3-14-57 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. J. Williams		ADDRESS (Street, city or town, state) Cumberland, Md.				DATE SIGNED 3-15-57	
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-18-57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 18, 1957	
				24b. REGISTRAR'S SIGNATURE W.R. Fantz, M.D.			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES P. HENRY		2. SEX M		3. AGE 45		4. DATE OF BIRTH JAN 15 1912	
5. PLACE OF BIRTH BALTIMORE, MD		6. OCCUPATION FARMER		7. MARITAL STATUS MARRIED		8. DATE OF DEATH MAY 10 1957	
9. PLACE OF DEATH HOME		10. CAUSE OF DEATH HEART DISEASE		11. MANNER OF DEATH NATURAL		12. SIGNATURE OF PHYSICIAN J. H. SMITH	
13. SIGNATURE OF REGISTRAR J. H. SMITH		14. SIGNATURE OF WITNESS J. H. SMITH		15. SIGNATURE OF WITNESS J. H. SMITH		16. SIGNATURE OF WITNESS J. H. SMITH	
17. SIGNATURE OF WITNESS J. H. SMITH		18. SIGNATURE OF WITNESS J. H. SMITH		19. SIGNATURE OF WITNESS J. H. SMITH		20. SIGNATURE OF WITNESS J. H. SMITH	
21. SIGNATURE OF WITNESS J. H. SMITH		22. SIGNATURE OF WITNESS J. H. SMITH		23. SIGNATURE OF WITNESS J. H. SMITH		24. SIGNATURE OF WITNESS J. H. SMITH	
25. SIGNATURE OF WITNESS J. H. SMITH		26. SIGNATURE OF WITNESS J. H. SMITH		27. SIGNATURE OF WITNESS J. H. SMITH		28. SIGNATURE OF WITNESS J. H. SMITH	
29. SIGNATURE OF WITNESS J. H. SMITH		30. SIGNATURE OF WITNESS J. H. SMITH		31. SIGNATURE OF WITNESS J. H. SMITH		32. SIGNATURE OF WITNESS J. H. SMITH	
33. SIGNATURE OF WITNESS J. H. SMITH		34. SIGNATURE OF WITNESS J. H. SMITH		35. SIGNATURE OF WITNESS J. H. SMITH		36. SIGNATURE OF WITNESS J. H. SMITH	
37. SIGNATURE OF WITNESS J. H. SMITH		38. SIGNATURE OF WITNESS J. H. SMITH		39. SIGNATURE OF WITNESS J. H. SMITH		40. SIGNATURE OF WITNESS J. H. SMITH	
41. SIGNATURE OF WITNESS J. H. SMITH		42. SIGNATURE OF WITNESS J. H. SMITH		43. SIGNATURE OF WITNESS J. H. SMITH		44. SIGNATURE OF WITNESS J. H. SMITH	
45. SIGNATURE OF WITNESS J. H. SMITH		46. SIGNATURE OF WITNESS J. H. SMITH		47. SIGNATURE OF WITNESS J. H. SMITH		48. SIGNATURE OF WITNESS J. H. SMITH	
49. SIGNATURE OF WITNESS J. H. SMITH		50. SIGNATURE OF WITNESS J. H. SMITH		51. SIGNATURE OF WITNESS J. H. SMITH		52. SIGNATURE OF WITNESS J. H. SMITH	
53. SIGNATURE OF WITNESS J. H. SMITH		54. SIGNATURE OF WITNESS J. H. SMITH		55. SIGNATURE OF WITNESS J. H. SMITH		56. SIGNATURE OF WITNESS J. H. SMITH	
57. SIGNATURE OF WITNESS J. H. SMITH		58. SIGNATURE OF WITNESS J. H. SMITH		59. SIGNATURE OF WITNESS J. H. SMITH		60. SIGNATURE OF WITNESS J. H. SMITH	
61. SIGNATURE OF WITNESS J. H. SMITH		62. SIGNATURE OF WITNESS J. H. SMITH		63. SIGNATURE OF WITNESS J. H. SMITH		64. SIGNATURE OF WITNESS J. H. SMITH	
65. SIGNATURE OF WITNESS J. H. SMITH		66. SIGNATURE OF WITNESS J. H. SMITH		67. SIGNATURE OF WITNESS J. H. SMITH		68. SIGNATURE OF WITNESS J. H. SMITH	
69. SIGNATURE OF WITNESS J. H. SMITH		70. SIGNATURE OF WITNESS J. H. SMITH		71. SIGNATURE OF WITNESS J. H. SMITH		72. SIGNATURE OF WITNESS J. H. SMITH	
73. SIGNATURE OF WITNESS J. H. SMITH		74. SIGNATURE OF WITNESS J. H. SMITH		75. SIGNATURE OF WITNESS J. H. SMITH		76. SIGNATURE OF WITNESS J. H. SMITH	
77. SIGNATURE OF WITNESS J. H. SMITH		78. SIGNATURE OF WITNESS J. H. SMITH		79. SIGNATURE OF WITNESS J. H. SMITH		80. SIGNATURE OF WITNESS J. H. SMITH	
81. SIGNATURE OF WITNESS J. H. SMITH		82. SIGNATURE OF WITNESS J. H. SMITH		83. SIGNATURE OF WITNESS J. H. SMITH		84. SIGNATURE OF WITNESS J. H. SMITH	
85. SIGNATURE OF WITNESS J. H. SMITH		86. SIGNATURE OF WITNESS J. H. SMITH		87. SIGNATURE OF WITNESS J. H. SMITH		88. SIGNATURE OF WITNESS J. H. SMITH	
89. SIGNATURE OF WITNESS J. H. SMITH		90. SIGNATURE OF WITNESS J. H. SMITH		91. SIGNATURE OF WITNESS J. H. SMITH		92. SIGNATURE OF WITNESS J. H. SMITH	
93. SIGNATURE OF WITNESS J. H. SMITH		94. SIGNATURE OF WITNESS J. H. SMITH		95. SIGNATURE OF WITNESS J. H. SMITH		96. SIGNATURE OF WITNESS J. H. SMITH	
97. SIGNATURE OF WITNESS J. H. SMITH		98. SIGNATURE OF WITNESS J. H. SMITH		99. SIGNATURE OF WITNESS J. H. SMITH		100. SIGNATURE OF WITNESS J. H. SMITH	

RECEIVED
MAR 19 1957
BUREAU V. S.

2369

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02. Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 So. Allegany St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle R. Last Carscaden				4. DATE OF DEATH Month March Day 17 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1871		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Ruppert				14. MOTHER'S MAIDEN NAME Dorothy Bullock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Arthur Carscaden Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x cerebral hemorrhage DUE TO generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO generalized arteriosclerosis (c) generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 16 19 57 to March 17 19 57 , that I last saw the deceased alive on March 16 19 57 , and that death occurred at 11:00 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE B. M. Schindler				ADDRESS (Street, city or town) state 411 Greenfield Cumberland Md 3/18/57			
PHYSICIAN'S NAME (Type) B. M. Schindler, M.D.				DATE SIGNED March 19, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.			
24a. REC'D BY REGISTRAR March 19, 1957				24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

42353

BUREAU V. S.

MAR 21 1957

RECEIVED

2370 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland		c. LENGTH OF STAY IN 1b 16 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural) Cumberland x 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D.#6 Klosterman Add.				d. STREET ADDRESS R.F.D.#6 Klosterman Add.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Francis Middle Elmo Last Coniff				4. DATE OF DEATH Month March Day 16 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 24-1899	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Kelley-Springfield Tire Co				10b. KIND OF BUSINESS OR INDUSTRY Keyser, W.Va.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James S. Coniff				14. MOTHER'S MAIDEN NAME Mary Houghton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.1				16. SOCIAL SECURITY NO. 217-14-4927		17. INFORMANT (daughter) Mary J. Shaffer, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary sclerosis (c) ? DUE TO (c) ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 17-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-19-57		22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland				24a. REC'D BY REGISTRAR March 19, 1957		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

MAR 21 1957

RECEIVED

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 237 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02391

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>138 Bedford St.</u>				d. STREET ADDRESS <u>138 Bedford St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nicholas</u> Middle <u>J.</u> Last <u>Coron</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 14-1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Candy maker</u>		11. BIRTHPLACE (State or foreign country) <u>Sparta, Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John N. Coron</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Levidiopis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-30-0119</u>		17. INFORMANT <u>Mrs. Agnes Chimes, Upper Darby, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial rupture</u> DUE TO <u>Coronary occlusion (left)</u> Conditions, if any, which gave rise to immediate cause (b) <u>body decomposed when found.</u> (c) <u>body decomposed when found.</u> DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 19-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 21, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>March 20, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH—BELLINGHAM 18
STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAR 22 1957
BUREAU V. 3

2418 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. #1, Box 80B, Frostburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Myrtle</u> Last <u>Crowe</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 10, 1885</u> 71 yrs.	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Avilton Garrett Co, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Francis Garlitz</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hetz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Frances Bostjancic</u> Address <u>Youngstown, Ohio</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Auricular Fibrillation</u> DUE TO (c) <u>Arteriosclerotic, Cardio-vascular, Hypertensive disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 minutes</u> <u>6 hrs 55 min</u> <u>± 15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary sclerosis and insufficiency</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/28</u> , 19 <u>48</u> , to <u>3/22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/22</u> , 19 <u>57</u> , and that death occurred at <u>5:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank T. Harbat</u>				ADDRESS (Street, city or town, state) <u>26 Mechanic St. Frostburg, Maryland</u>			
DATE SIGNED <u>3/23/57</u>							
PHYSICIAN'S NAME (Type) <u>FRANK T. HARBAT M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Allegany Co, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard H. Whitesent</u>				ADDRESS <u>Frostburg, Md</u>		24a. REC'D BY REGISTRAR <u>3-26-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. Harvey N. Poe</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

18

1967

BUREAU V. S.

APR 1 1967

RECEIVED

1. NAME OF DECEASED <i>James Earl Ray</i>		2. SEX <i>Male</i>		3. AGE <i>35</i>	
4. DATE OF DEATH <i>April 4, 1968</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>San Francisco, California</i>	
7. CAUSE OF DEATH <i>Shot</i>		8. MANNER OF DEATH <i>Suicide</i>		9. PLACE OF BIRTH <i>London, England</i>	
10. OCCUPATION <i>Actor</i>		11. MARITAL STATUS <i>Single</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SIGNATURE OF DECEASED <i>James Earl Ray</i>	
16. SIGNATURE OF WITNESS <i>James Earl Ray</i>		17. SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>		18. SIGNATURE OF CORONER <i>James Earl Ray</i>	

Outside of
County

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02393

2372

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural- Cumberland x2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D.#3 Bowman's Addition				d. STREET ADDRESS R.F.D.#3 Bowman's Addition		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Virginia Dawson				4. DATE OF DEATH Month Day Year March 4 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 Feb. 29-1884	
9. AGE (in years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Junction, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac (Iser) Riley				14. MOTHER'S MAIDEN NAME Lydia Keener			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address Sacred Heart Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4222 DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic myocarditis with hypertrophy, also (c) had edema of lungs also extremities DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE H.V. Deming M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) H.V. Deming M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 4-1957 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF March 6, 1957 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland. 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John J. Hafer, Cumberland, Maryland 24a. REC'D BY REGISTRAR March 5, 1957 24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.							

1957 2 188

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2373 CERTIFICATE OF DEATH

02394

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 36 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL			d. STREET ADDRESS 725 BEDFORD STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First THOMAS Middle J. Last DAWSON			4. DATE OF DEATH Month MARCH Day 12 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1874 OCTOBER 9, 1874	9. AGE (In years last birthday) yrs. 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dairy Farmer Self employed			10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME ELI W. DAWSON			14. MOTHER'S MAIDEN NAME LUCY JACOBS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-32-3320		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertensive Arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) vascular disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 37 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2.4.1957 to 2.12.1957 , that I last saw the deceased alive on 2.12.1957 , and that death occurred at 4:40 P. M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE W. F. Williams		M.D. 177 S. Centre St. Cumberland		DATE SIGNED Feb 15	
PHYSICIAN'S NAME (Type) WILLIAM F. WILLIAMS, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/57	22c. NAME OF CEMETERY OR CREMATORY Hillcrest		22d. LOCATION (City, town, or county) (State) Cumberland. Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox			ADDRESS Cumberland. Md.		
24a. REC'D BY REGISTRAR March 14, 1957		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M-

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

2419

02395

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Westernport</u>				TOWN <u>43 Westernport,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>223 Hammond Street,</u>				STREET ADDRESS <u>1</u> (If rural give location) <u>223 Hammond Street.</u>			
3. NAME OF DECEASED (Type or Print) <u>Bert Shields Dayton</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>25</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 11, 1879.</u>	
9. AGE last birthday <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Westernport, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Henry C. Dayton.</u>				14. MOTHER'S MAIDEN NAME <u>Emma Dawson.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Westernport Md.</u> <u>Mrs. Manie Dayton.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
18. MEDICAL CERTIFICATION							
IMMEDIATE CAUSE (A) <u>Chronic endocarditis and chronic Myocarditis with Myocardial Degeneration specified as Rheumatic</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Rheumatic Fever</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Bronchitis with Asthma</u>							
19a. DATE OF OPERATION <u>None</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 10</u> , 19 <u>55</u> , to <u>Mar. 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar. 23</u> , 19 <u>57</u> , and that death occurred at <u>12:41 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Paul B. Wilson</u> M.D.				ADDRESS (Street, city, town, state) <u>Piedmont W. Va.</u>			
DATE SIGNED <u>Mar. 25, 1957</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-27-1957</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery,</u>		LOCATION (City, town, or county) (State) <u>Westernport, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Joan C Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Harold Fullbrook Jr.</u>		ADDRESS <u>Piedmont, West Va.</u>	
DATE <u>3-27-57</u>							

13300

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF REGISTRAR

18. SIGNATURE OF VENDOR

19. SIGNATURE OF SELLER

20. SIGNATURE OF BUYER

21. SIGNATURE OF TRANSFEREE

22. SIGNATURE OF TRANSFEROR

23. SIGNATURE OF ENDORSEMENT

24. SIGNATURE OF RECEIPT

25. SIGNATURE OF DELIVERY

26. SIGNATURE OF ACCEPTANCE

27. SIGNATURE OF CANCELLATION

28. SIGNATURE OF REVERSAL

29. SIGNATURE OF REFUND

30. SIGNATURE OF RETURN

31. SIGNATURE OF EXCHANGE

32. SIGNATURE OF TRANSFER

33. SIGNATURE OF ASSIGNMENT

34. SIGNATURE OF DEED

35. SIGNATURE OF MORTGAGE

36. SIGNATURE OF LEASE

37. SIGNATURE OF EASEMENT

38. SIGNATURE OF LICENSE

39. SIGNATURE OF PERMIT

40. SIGNATURE OF CERTIFICATE

41. SIGNATURE OF ORDER

42. SIGNATURE OF WARRANT

43. SIGNATURE OF SUBPOENA

44. SIGNATURE OF RETURN

45. SIGNATURE OF RECEIPT

46. SIGNATURE OF DELIVERY

47. SIGNATURE OF ACCEPTANCE

48. SIGNATURE OF CANCELLATION

49. SIGNATURE OF REVERSAL

50. SIGNATURE OF REFUND

51. SIGNATURE OF RETURN

52. SIGNATURE OF EXCHANGE

53. SIGNATURE OF TRANSFER

54. SIGNATURE OF ASSIGNMENT

55. SIGNATURE OF DEED

56. SIGNATURE OF MORTGAGE

57. SIGNATURE OF LEASE

58. SIGNATURE OF EASEMENT

59. SIGNATURE OF LICENSE

60. SIGNATURE OF PERMIT

61. SIGNATURE OF CERTIFICATE

62. SIGNATURE OF ORDER

63. SIGNATURE OF WARRANT

64. SIGNATURE OF SUBPOENA

65. SIGNATURE OF RETURN

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69. SIGNATURE OF CANCELLATION

70. SIGNATURE OF REVERSAL

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95. SIGNATURE OF TRANSFER

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121. SIGNATURE OF EASEMENT

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132. SIGNATURE OF CANCELLATION

133. SIGNATURE OF REVERSAL

134. SIGNATURE OF REFUND

135. SIGNATURE OF RETURN

136. SIGNATURE OF EXCHANGE

137. SIGNATURE OF TRANSFER

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140. SIGNATURE OF MORTGAGE

141. SIGNATURE OF LEASE

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144. SIGNATURE OF PERMIT

145. SIGNATURE OF CERTIFICATE

146. SIGNATURE OF ORDER

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148. SIGNATURE OF SUBPOENA

149. SIGNATURE OF RETURN

150. SIGNATURE OF RECEIPT

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152. SIGNATURE OF ACCEPTANCE

153. SIGNATURE OF CANCELLATION

154. SIGNATURE OF REVERSAL

155. SIGNATURE OF REFUND

156. SIGNATURE OF RETURN

157. SIGNATURE OF EXCHANGE

158. SIGNATURE OF TRANSFER

159. SIGNATURE OF ASSIGNMENT

160. SIGNATURE OF DEED

161. SIGNATURE OF MORTGAGE

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163. SIGNATURE OF EASEMENT

164. SIGNATURE OF LICENSE

165. SIGNATURE OF PERMIT

166. SIGNATURE OF CERTIFICATE

167. SIGNATURE OF ORDER

168. SIGNATURE OF WARRANT

169. SIGNATURE OF SUBPOENA

170. SIGNATURE OF RETURN

171. SIGNATURE OF RECEIPT

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174. SIGNATURE OF CANCELLATION

175. SIGNATURE OF REVERSAL

176. SIGNATURE OF REFUND

177. SIGNATURE OF RETURN

178. SIGNATURE OF EXCHANGE

179. SIGNATURE OF TRANSFER

180. SIGNATURE OF ASSIGNMENT

181. SIGNATURE OF DEED

182. SIGNATURE OF MORTGAGE

183. SIGNATURE OF LEASE

184. SIGNATURE OF EASEMENT

185. SIGNATURE OF LICENSE

186. SIGNATURE OF PERMIT

187. SIGNATURE OF CERTIFICATE

188. SIGNATURE OF ORDER

189. SIGNATURE OF WARRANT

190. SIGNATURE OF SUBPOENA

191. SIGNATURE OF RETURN

192. SIGNATURE OF RECEIPT

193. SIGNATURE OF DELIVERY

194. SIGNATURE OF ACCEPTANCE

195. SIGNATURE OF CANCELLATION

196. SIGNATURE OF REVERSAL

197. SIGNATURE OF REFUND

198. SIGNATURE OF RETURN

199. SIGNATURE OF EXCHANGE

200. SIGNATURE OF TRANSFER

201. SIGNATURE OF ASSIGNMENT

202. SIGNATURE OF DEED

203. SIGNATURE OF MORTGAGE

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205. SIGNATURE OF EASEMENT

206. SIGNATURE OF LICENSE

207. SIGNATURE OF PERMIT

208. SIGNATURE OF CERTIFICATE

209. SIGNATURE OF ORDER

210. SIGNATURE OF WARRANT

211. SIGNATURE OF SUBPOENA

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215. SIGNATURE OF ACCEPTANCE

216. SIGNATURE OF CANCELLATION

217. SIGNATURE OF REVERSAL

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227. SIGNATURE OF LICENSE

228. SIGNATURE OF PERMIT

229. SIGNATURE OF CERTIFICATE

230. SIGNATURE OF ORDER

231. SIGNATURE OF WARRANT

232. SIGNATURE OF SUBPOENA

233. SIGNATURE OF RETURN

234. SIGNATURE OF RECEIPT

235. SIGNATURE OF DELIVERY

236. SIGNATURE OF ACCEPTANCE

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238. SIGNATURE OF REVERSAL

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243. SIGNATURE OF ASSIGNMENT

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247. SIGNATURE OF EASEMENT

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249. SIGNATURE OF PERMIT

250. SIGNATURE OF CERTIFICATE

251. SIGNATURE OF ORDER

252. SIGNATURE OF WARRANT

253. SIGNATURE OF SUBPOENA

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255. SIGNATURE OF RECEIPT

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258. SIGNATURE OF CANCELLATION

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278. SIGNATURE OF ACCEPTANCE

279. SIGNATURE OF CANCELLATION

280. SIGNATURE OF REVERSAL

281. SIGNATURE OF REFUND

282. SIGNATURE OF RETURN

283. SIGNATURE OF EXCHANGE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02396

CERTIFICATE OF DEATH

Reg. Dist. No. 14

2435

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CORRIGANVILLE</u>		LENGTH OF STAY (in this place) <u>LIFE</u>		CITY OR TOWN <u>CORRIGANVILLE</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) <u>Nellie</u> (First) <u>Mac</u> (Middle) <u>Dickel</u> (Last)				4. DATE OF DEATH <u>MARCH 30</u> 19 <u>57</u> (Month) (Day) (Year)			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>NOV. 18, 1884</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MT. SAUCE, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levi Blank</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE Wilhelm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>CARL Dickel, CORRIGANVILLE Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.2 IMMEDIATE CAUSE (A) <u>Chronic myocardosis</u></u>						<u>5 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>50</u> , to <u>Mar 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 30</u> , 19 <u>57</u> , and that death occurred at <u>7 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>John R. Topper</u>				ADDRESS (Street, city, town, state) <u>Hyndman Pa</u>		DATE SIGNED <u>4-1-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>APRIL 2, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>ST. PATRICKS CEMETERY</u>		LOCATION (City, town, or county) (State) <u>MT. SAUCE, Md</u>	
24. REC'D BY REGISTRAR DATE <u>Apr 1 1957</u>		REGISTRAR'S SIGNATURE <u>Lloyd Wolfe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey N. Ziegler</u>		ADDRESS <u>Hyndman, Pa</u>	

BUREAU V. S.

APR 3 1957

RECEIVED

2374

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 231 Oak St., 1	
3. NAME OF DECEASED (Type or print) First Raymond Middle DiGilarmo Last DiGilarmo		4. DATE OF DEATH Month March Day 9 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/1889
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dominic DiGilarmo		14. MOTHER'S MAIDEN NAME Teresa ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Patients chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis - (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH Instantly 10 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right Hemiplegia - Left Cerebral Thromboses			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 7, 1957 to March 9, 1957 , that I last saw the deceased alive on March 8, 1957 , and that death occurred at 12:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Saville G. Weisman		M.D. 59 Greencroft St	
PHYSICIAN'S NAME (Type) Saville G. WEISMAN		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-14-57	
22c. NAME OF CEMETERY OR CREMATORY St. Patrick's		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR March 13, 1957		24b. REGISTRAR'S SIGNATURE W. R. Frank M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

MAR 15 1957

RECEIVED

2436 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>43 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>R.F.D. #6, Narrows Addition</u>			e. STREET ADDRESS <u>R.F.D. #6, Narrows Addition</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Roman</u> Last <u>Roman</u>			4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2 1884</u>		9. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Building House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Roman WVA</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Edward Roman</u>		
14. MOTHER'S MAIDEN NAME <u>Amanda Marshall</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>215-164675</u>			17. INFORMANT <u>George Colahan Carrigsville Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis contracted Keshug</u> DUE TO (c) <u>generalized arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 years</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>3-10</u> , 19 <u>57</u> , to <u>3-10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-10</u> , 19 <u>57</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>L. Wins</u>			M.D. <u>57 Greene</u>		
PHYSICIAN'S NAME (Type) <u>LEWIS BRINGS</u>			ADDRESS (Street, city or town, state) <u>Cumberland Md</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Near Moorefield W Va</u>		(State) <u>W Va</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Night</u>	
23. ADDRESS <u>Cumberland Md</u>		24a. REC'D BY REGISTRAR <u>March 11/57</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

2375

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>30 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>412 Columbia St.</u>				d. STREET ADDRESS <u>412 Columbia St</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Fay</u> Last <u>Dormio</u>				4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 16, 1914</u>		9. AGE (In years last birthday) <u>43 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Barton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles Coyle</u>				14. MOTHER'S MAIDEN NAME <u>Janet Preston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-4791</u>		17. INFORMANT <u>Vito Dormio, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9 Carcinoma Ovary</u> <u>175x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized metastasis</u> DUE TO (c) <u>5 yrs.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>March, 1952</u> to <u>3/29</u> , 1957, that I last saw the deceased alive on <u>3/29</u> , 1957, and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>George M. Simons</u> M.D. <u>Cumberland, Md.</u> <u>4/1/57</u> PHYSICIAN'S NAME (Type) <u>George Simons</u> <u>Cumberland, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafner</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>April 2, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Frank, M.D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 3 1957

BUREAU V. S.

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, 18	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. RACE	
5. OCCUPATION	
6. PLACE OF BIRTH	
7. DATE OF BIRTH	
8. DATE OF DEATH	
9. PLACE OF DEATH	
10. CAUSE OF DEATH	
11. MANNER OF DEATH	
12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR	
14. SIGNATURE OF WITNESS	
15. SIGNATURE OF DECEASED	
16. SIGNATURE OF NEXT OF KIN	
17. SIGNATURE OF BURIAL OFFICIAL	
18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF CHURCH	
20. SIGNATURE OF OTHER	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2378 CERTIFICATE OF DEATH

Reg. Dist. No.

02400

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
c. LENGTH OF STAY IN 1b 11/30/56				d. STREET ADDRESS 913 Grand Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Benjamin Middle F. Last Drenning				4. DATE OF DEATH Month March Day 13 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/11/1876	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life) Retired - Weight Master Railroad		11. BIRTHPLACE (State or foreign country) Piedmont, W. Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William C. Drenning		14. MOTHER'S MAIDEN NAME Evelyn Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-07-6683		17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis (c) Chronic Myocarditis							INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Prostatitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11/30/56 , 19____, to 3/13/57 , 19____, that I last saw the deceased alive on 3/13/57 , 19____, and that death occurred at 4:00 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. McLean M.D.				ADDRESS (Street, city or town, state) 49 Greene Street			
PHYSICIAN'S NAME (Type) Dr. James E. McLean, Md.				DATE SIGNED 3/13/57			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		March 16/1957		Rose Hill Cem		Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc. Cumberland Md				24a. REC'D BY REGISTRAR March 14/1957		24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	

CERTIFICATE OF DEATH

NAME OF DECEASED Allegory		MARRIAGE HARRIS	
DATE OF DEATH 1957		PLACE OF DEATH Allegory town, Allegory	
AGE 30		SEX Male	
RACE White		EDUCATION High School	
OCCUPATION Laborer		MANNER OF DEATH Natural	
CAUSE OF DEATH Heart Disease		IMMEDIATE CAUSE OF DEATH Myocardial Infarction	
DATE OF BIRTH 1927		PLACE OF BIRTH Allegory, W. Virginia	
FATHER'S NAME Robert E. Allegory		MOTHER'S NAME Mary E. Allegory	
FATHER'S OCCUPATION Farmer		MOTHER'S OCCUPATION Homemaker	
FATHER'S DATE OF BIRTH 1897		MOTHER'S DATE OF BIRTH 1907	
FATHER'S PLACE OF BIRTH Allegory, W. Virginia		MOTHER'S PLACE OF BIRTH Allegory, W. Virginia	
FATHER'S MARRIAGE 1922		MOTHER'S MARRIAGE 1922	
FATHER'S DEATH 1955		MOTHER'S DEATH 1955	
FATHER'S CAUSE OF DEATH Heart Disease		MOTHER'S CAUSE OF DEATH Heart Disease	
FATHER'S IMMEDIATE CAUSE OF DEATH Myocardial Infarction		MOTHER'S IMMEDIATE CAUSE OF DEATH Myocardial Infarction	
FATHER'S DATE OF BIRTH 1897		MOTHER'S DATE OF BIRTH 1907	
FATHER'S PLACE OF BIRTH Allegory, W. Virginia		MOTHER'S PLACE OF BIRTH Allegory, W. Virginia	
FATHER'S MARRIAGE 1922		MOTHER'S MARRIAGE 1922	
FATHER'S DEATH 1955		MOTHER'S DEATH 1955	
FATHER'S CAUSE OF DEATH Heart Disease		MOTHER'S CAUSE OF DEATH Heart Disease	
FATHER'S IMMEDIATE CAUSE OF DEATH Myocardial Infarction		MOTHER'S IMMEDIATE CAUSE OF DEATH Myocardial Infarction	

BURKAY T. S.

MAR 15 1957

RECEIVED

2437

CERTIFICATE OF DEATH

02401

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westernport		c. LENGTH OF STAY IN 1b 83 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stoney Run Road		e. STREET ADDRESS Stoney Run Road /	
3. NAME OF DECEASED (Type or print) First Linda Middle Belle Last Duckworth		4. DATE OF DEATH Month Mar. Day 5 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thornton Duckworth		14. MOTHER'S MAIDEN NAME Ollie Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. 00	
17. INFORMANT Patrick Duckworth-Lonaconing, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration. Not specified as Rheumatic 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 24, 1957 , to Mar. 5, 1957 , that I last saw the deceased alive on Mar. 3, 1957 , and that death occurred at 4:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul R. Wilson		ADDRESS (Street, city or town, state) Piedmont, W. Va. DATE SIGNED Mar. 6, 1957	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/57	
22c. NAME OF CEMETERY OR CREMATORY Miller Cem,		22d. LOCATION (City, town, or county) (State) Allegany Ct. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. S. Beal		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR DATE 3-7-57		24b. REGISTRAR'S SIGNATURE John C. Kelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>		<p>9. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>10. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>11. SIGNATURE OF WITNESS [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED [REDACTED]</p>	

BUREAU V. S.

MAR 11 1957

RECEIVED

2377 CERTIFICATE OF DEATH

02402

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b # 3 mon. 3 wks x 2 RAWLINGS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		d. STREET ADDRESS 1 None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK LIN Middle R. Last Galliher		4. DATE OF DEATH Month 3-27-57 Day 19 Year 19	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 3, 1898
9. AGE (In years lost birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Elias Galliher		14. MOTHER'S MAIDEN NAME Florence V. Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) War L.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address Mr. John Galliher Rawlings, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterial hypertension 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) nephrosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 26 , 19 55 , to March 27 , 19 57 , that I last saw the deceased alive on March 26 , 19 57 , and that death occurred at 7:55 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 55 GREEN ST., CUMBERLAND, MD. DATE SIGNED	
ACTUAL SIGNATURE Elizabeth Brings M.D.			
PHYSICIAN'S NAME (Type) ELIZABETH BRINGS, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-30-1957	
22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.		24. REC'D BY REGISTRAR March 29, 1957 24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

STATE DEPARTMENT OF HEALTH - BATHING

1957

BUREAU V. S.

APR 1 1957

RECEIVED

2420 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
c. LENGTH OF STAY IN 1b 4 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS 66 Bowery St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNIE Middle K. Last GUNNETT		4. DATE OF DEATH Month March Day 30 , Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Krouse		14. MOTHER'S MAIDEN NAME Martha E. Lemmert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-12-8906B	
17. INFORMANT Harry Gunnett, Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio Sclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH several days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 1, 1956 , to Mar 30, 1957 , that I last saw the deceased alive on Mar 30, 1957 , and that death occurred at 7:20 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE WOM Lane		M.D. Frostburg	
PHYSICIAN'S NAME (Type) WOM Lane MD		DATE SIGNED Apr 1/1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-2-57	22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR DATE 4-2-57		24b. REGISTRAR'S SIGNATURE Dr. Stanley R. Rose	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 11 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 10
CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH - BALTIMORE 10
AND IN THE COUNTY OF [illegible] IN THE STATE OF MARYLAND
TO REMAIN PERMANENTLY ON FILE IN THE DEPARTMENT OF HEALTH - BALTIMORE 10
AND IN THE COUNTY OF [illegible] IN THE STATE OF MARYLAND
TO REMAIN PERMANENTLY ON FILE IN THE DEPARTMENT OF HEALTH - BALTIMORE 10
AND IN THE COUNTY OF [illegible] IN THE STATE OF MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG212 3-19-57 et

2378 CERTIFICATE OF DEATH

Reg. Dist. No.

02403

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5 Min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Elizabeth Middle Hartman Last Hartman		4. DATE OF DEATH Month 3 Day 12 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1880
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 12 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Bender		14. MOTHER'S MAIDEN NAME Des Nelda Reinhard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Geo. V. Hartman		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/12 , 19 57 , to 3/12 , 19 57 , that I last saw the deceased alive on 3/12 , 19 57 , and that death occurred at 10:05 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo H. Ley Jr. M.D.		ADDRESS (Street, city or town, state) 452 N. Centre St. Cumberland, Md.	
DATE SIGNED 3/12/57			
PHYSICIAN'S NAME (Type) LEO H. LEY JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-15-57	
22c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cem		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR March 13, 1957		24b. REGISTRAR'S SIGNATURE W.R. Grantz M.D.	

BUREAU V. S.

BUREAU V. S.

Within corporate limits.

2379 CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HARDY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> MOOREFIELD, W.VA.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, CUMBERLAND, MD.				d. STREET ADDRESS 85X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MRS. MARTHA ELLEN HEAVNER				4. DATE OF DEATH Month Day Year MARCH 27 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/20/1877	
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) W.VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME -----				14. MOTHER'S MAIDEN NAME MARTHA V. HEAVNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomatosis 153X DUE TO (b) Carcinoma descending colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 8 months.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4 Feb. 1957 to 27 Mar. 1957 that I last saw the deceased alive on 27 Mar. 1957 , and that death occurred at 10:00 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE W. A. Van Ormer				ADDRESS (Street, city or town, state) M.D. Cumberland, Md.		DATE SIGNED 27 Mar. 57	
PHYSICIAN'S NAME (Type) W. A. VAN ORMER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Mar 30-1957		22c. NAME OF CEMETERY OR CREMATORY Scott Cemetery		22d. LOCATION (City, town, or county) (State) Burgess - W.Va	
23. FUNERAL DIRECTOR'S SIGNATURE Earl B. Marshall				ADDRESS Moorefield, W.Va		24a. REC'D BY REGISTRAR March 28, 1957	
						24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first step is to identify the key components of the system. This involves understanding the hardware, software, and data involved in the process.

THE UNIVERSITY OF CHICAGO

536-001

514

RECEIVED JAN 19 1968

BUREAU V. 8

MAR 29 1957

RECEIVED

2335 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Allegany, Md</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresaltown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>244 Meadowview Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Lorenza</u> Middle <u>Helmich Jr.</u> Last <u>Helmich</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 26 - 1916</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 MRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elementary Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wiley End, W.D. School</u>		11. BIRTHPLACE (State or foreign country) <u>Davis, W. Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Lorenza W. Helmich</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Helmich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>236-32-5004 (wif)</u>		17. INFORMANT <u>Ursula Helmich, Cresaltown, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Downing M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Downing M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 14 - 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 16, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sugar Land Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Thomas, West Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Spiggle</u>				ADDRESS <u>Davis, W. Va</u>		24a. REC'D BY REGISTRAR <u>March 14, 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. R. Frantz, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, or removal.

RECEIVED

MAR 15 1957

BUREAU V. 3

2381 CERTIFICATE OF DEATH

Reg. Dist. No.

02406

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5/11/56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julius Middle Henry Last Hessinger		4. DATE OF DEATH Month March Day 11 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/22/1880
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Brick Layer & Setter		9b. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Brick Layer & Setter		10b. KIND OF BUSINESS OR INDUSTRY Columbus, Ohio	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Josiah Hessinger		14. MOTHER'S MAIDEN NAME Castie Harper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-10-1263	
17. INFORMANT P.O.Box 599, Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis (c) Cerebral hemorrhage			INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic nephritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/11/56 , 19____, to 3/11/57 , 19____, that I last saw the deceased alive on 3/11/57 , 19____, and that death occurred at 7:20A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean, M.D.		DATE SIGNED 3/11/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 13, 1957	22c. NAME OF CEMETERY OR CREMATORY St. Luke & Rebekah Co. Hallerbury Pa.	22d. LOCATION (City, town, or county) (State) Pa.
23. FUNERAL-DIRECTOR'S SIGNATURE Lowis Stein Inc		24a. REC'D BY REGISTRAR March 14, 1957	
ADDRESS Cumberland		24b. REGISTRAR'S SIGNATURE W.R. Hantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	
CITY OF BALTIMORE [Illegible]		COUNTY OF BALTIMORE [Illegible]	
STATE OF MARYLAND [Illegible]		[Illegible]	

BUREAU V. 2

MAR 15 1957

RECEIVED

2382 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hosp.		d. STREET ADDRESS 1784 Fayette St.,	
3. NAME OF DECEASED (Type or print) ARLET HINZMAN		4. DATE OF DEATH Month March Day 8, Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1893
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retires Ins. Rep.		10b. KIND OF BUSINESS OR INDUSTRY Peoples Life Ins.	
11. BIRTHPLACE (State or foreign country) Camden, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William Hinzman		14. MOTHER'S MAIDEN NAME Mary Lamb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes, W. W. # 1		16. SOCIAL SECURITY NO. W. W. # 1	
17. INFORMANT Mrs. Frances Hinzman		Address 784 Fayette St., Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-7- , 19 57 , to 3-8- , 19 57 , that I last saw the deceased alive on 3-8- , 19 57 , and that death occurred at 8:10 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE L. B. Mathews M.D. 49 Greene St., 3/9/57			
PHYSICIAN'S NAME (Type) L. B. Mathews M. D.		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/11/57	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR March 11, 1957		24b. REGISTRAR'S SIGNATURE W. K. Frank M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 13 1957

BUREAU V. S.

2385 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b $\frac{1}{2}$ hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS 1707 Piedmont Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Salem Middle Humbertson Last Humbertson				4. DATE OF DEATH Month March Day 27 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15-1893		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto salesman		10b. KIND OF BUSINESS OR INDUSTRY Chevrolet Garage		11. BIRTHPLACE (State or foreign country) Ocean, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Humbertson				14. MOTHER'S MAIDEN NAME Amanda Burton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-6364		17. INFORMANT Genevieve Address Md. (wife) Mrs. Genevieve Humbertson, Cumberland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 hrs. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 27-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 30, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.				24a. REC'D BY REGISTRAR March 28, 1957 24b. REGISTRAR'S SIGNATURE W.K. Frank, M.D.			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAR 20 1957

RECEIVED

2384 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 2/20/57			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Esther Middle Charlotte Last Jobson				4. DATE OF DEATH Month March Day 11 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/30/1880	
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Barton, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George Langham				14. MOTHER'S MAIDEN NAME Susana Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT P.O.Box 599, Address Cumberland, Md. Allegany County Infirmary Records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Sclerosis INTERVAL BETWEEN ONSET AND DEATH 48 hrs.							
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Chronic Myocarditis ?							
(c) Cerebral Arteriosclerosis ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) osteoarthritis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/20/57 , 19____, to 3/11/57 , 19____, that I last saw the deceased alive on 3/11/57 , 19____, and that death occurred at 5:45 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE James E. McLean M.D. 49 Greene Street				3/12/57			
PHYSICIAN'S NAME (Type) Dr. James E. McLean, M.D. Cumberland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Boal Funeral Home, Westernport, Maryland.				24a. REC'D BY REGISTRAR March 13, 1957			
				24b. REGISTRAR'S SIGNATURE W. K. Frantz, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
George Jackson		35		Male		White		March 15, 1957		Baltimore, Maryland	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation		Education	
Pneumonia		Pneumonia		Pneumonia		Natural		Carpenter		High School	
Date of Birth		Place of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Death		Place of Death	
March 15, 1957		Baltimore, Maryland		March 15, 1957		March 15, 1957		March 15, 1957		Baltimore, Maryland	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Death Certifier		Signature of Death Certifier	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

MAR 15 1957

RECEIVED

2385

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(rural) Cumberland</u> <u>X2</u>	
c. LENGTH OF STAY IN 1b <u>25 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>806 Maryland Ave.</u>		d. STREET ADDRESS <u>Route #4 Mexico Farm</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Martin B. Johnson</u>		4. DATE OF DEATH <u>March 18 19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 29-1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Self Employed Carp.</u>	
13. BIRTHPLACE (State or foreign country) <u>Ashville Pa.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>William F. Johnson</u>		16. MOTHER'S MAIDEN NAME <u>Catherine Conrad</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		18. SOCIAL SECURITY NO. <u>214-05-6099</u>	
19. INFORMANT <u>Mrs. Joseph E. Johnson</u>		Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 18-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/21/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>March 20, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Frank, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAR 22 1957

BUREAU V. 1

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2386 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY MARYLAND Allegany			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.			c. LENGTH OF STAY IN 1b 35 hrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. STREET ADDRESS 320 Fayette St.					
3. NAME OF DECEASED (Type or print) First Edward Middle Sylvester Last Keating			4. DATE OF DEATH Month 3/29/57 Day 19 Year 19		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/96	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail store salesman		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) New York City	
13. FATHER'S NAME Edward S. Keating		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME Phoebe King Keating					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 282-09-9922		17. INFORMANT Patient's Chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO benign arterial disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) and sinusoidal fibrillation DUE TO (c) years					INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Jan 25 , 19 57 , to March 29 , 19 57 that I last saw the deceased alive on March 25 , 19 57 , and that death occurred at 4:57 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE B. M. Schindler		M.D. 4/1		ADDRESS (Street, city, or town, state) Cumberland, Md. DATE SIGNED 3/19/57	
PHYSICIAN'S NAME (Type) Blaine M. Schindler M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/1/57		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	
22d. LOCATION (City, town, or county) (State) Cumberland, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 29, 1957 24b. REGISTRAR'S SIGNATURE W. A. Frank M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS DEATH CERTIFICATE

Name of Deceased [Faint text]		Date of Birth [Faint text]	
Sex [Faint text]		Race [Faint text]	
Usual Residence [Faint text]		Date of Death [Faint text]	
Cause of Death [Faint text]		Place of Death [Faint text]	
Physician's Signature [Faint text]		Registrar's Signature [Faint text]	
Date of Issue [Faint text]		Office of Registrar [Faint text]	

BUREAU V. S.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02412

2387 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Apt. 10-B Jane Frazier Village		d. STREET ADDRESS Apt. 10-B Jane Frazier Village	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DANIEL Middle FREDERICK Last KEEFAUVER		4. DATE OF DEATH Month March Day 21 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1893
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired telegrapher		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	
11. BIRTHPLACE (State or foreign country) Waynesboro, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William A. Keefauver		14. MOTHER'S MAIDEN NAME Charlotte Johnston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 705-05-5939	
17. INFORMANT Mrs. Mary F. Keefauver Jane Frazier Village,		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 mo 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-3- , 19 55 , to 3-21 , 19 57 , that I last saw the deceased alive on 3-19- , 19 57 , and that death occurred at 10:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Greene St., DATE SIGNED ACTUAL SIGNATURE L. M. M. D. PHYSICIAN'S NAME (Type) Lewis Brings M. D. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/57	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR March 23, 1957		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M. D.	

32115

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

2001 CERTIFICATE OF DEATH

Deceased's Name		Date of Birth		Sex	
Mary P. Leary		Jan. 10, 1903		Female	
Married Name		Date of Marriage		Place of Birth	
John P. Leary		Jan. 10, 1903		Maryland	
Cause of Death		Date of Death		Place of Death	
Heart Disease		Jan. 10, 1903		Maryland	
Physician's Name		Signature		Hospital Name	
Dr. J. P. Leary		[Signature]		St. Mary's Hospital	
Burial Place		Date of Burial		Burial Place	
St. Mary's Cemetery		Jan. 10, 1903		St. Mary's Cemetery	

BUREAU V. 3

MAR 27 1957

RECEIVED

2388 CERTIFICATE OF DEATH

02413

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle EDWARD Last KESLER				4. DATE OF DEATH Month MARCH Day 19 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 27, 1908	
9. AGE (In years last birthday) yrs. 48		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Potomac Edison Co.		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Absolm T. KESLER			
14. MOTHER'S MAIDEN NAME KATHERINE BOXELL				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 214-05-9537				17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) Chronic Rheumatic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Feb , 1957, to March , 1957, that I last saw the deceased alive on March 18 , 1957, and that death occurred at 5:35 A. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) 133 Virginia Ave, Cumberland Md			
DATE SIGNED 3/19/57				M.D. [Signature]			
PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/57		22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul's		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 21, 1957	
24b. REGISTRAR'S SIGNATURE W-R. Frantz, M.D.							

RECEIVED

MAR 22 1957

BUREAU V. S.

DR. RANSOM

2389
CERTIFICATE OF DEATH

Reg. Dist. No.

02414

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE LAST BABY BOY KETTERMAN		4. DATE OF DEATH Month MARCH Day 1 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 25, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GROVER KETTERMAN		14. MOTHER'S MAIDEN NAME EDNA M. WINFIELD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.0 DUE TO Immature development of vital functions 4 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 25 Feb., 1957, to 1 March, 1957, that I last saw the deceased alive on 1 March, 1957, and that death occurred at 11:22 P.M., from the causes and on the date stated above.					
ACTUAL SIGNATURE Leland Ransom M.D.		ADDRESS (Street, city or town, state) 63 Greene St., Cumberland Md		DATE SIGNED 2 March 57	
PHYSICIAN'S NAME (Type) DR. LELAND RANSOM					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY SS Peter + Paul Ch.	
				22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS Cumb Md		24a. REC'D BY REGISTRAR March 2, 1957	
				24b. REGISTRAR'S SIGNATURE W. K. Kautz, M.D.	

2060264XYI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. HENRY		2. SEX MALE		3. AGE 65	
4. RACE WHITE		5. BIRTH DATE JAN 15 1892		6. PLACE OF BIRTH BALTIMORE, MARYLAND	
7. OCCUPATION LABORER		8. MARITAL STATUS MARRIED		9. PLACE OF DEATH BALTIMORE, MARYLAND	
10. DATE OF DEATH MAR 4 1957		11. TIME OF DEATH 10:30 AM		12. CAUSE OF DEATH HEART DISEASE	
13. PLACE OF INTERMENT CATHOLIC CHURCH		14. SIGNATURE OF DECEASED (None)		15. SIGNATURE OF WITNESSES (None)	
16. SIGNATURE OF PHYSICIAN (None)		17. SIGNATURE OF CORONER (None)		18. SIGNATURE OF REGISTRAR (None)	
19. SIGNATURE OF DECEASED'S NEAREST RELATIVE (None)		20. SIGNATURE OF DECEASED'S NEXT OF KIN (None)		21. SIGNATURE OF DECEASED'S ATTORNEY (None)	
22. SIGNATURE OF DECEASED'S MINISTER (None)		23. SIGNATURE OF DECEASED'S CHURCH (None)		24. SIGNATURE OF DECEASED'S FUNERAL HOME (None)	
25. SIGNATURE OF DECEASED'S BURIAL PLACE (None)		26. SIGNATURE OF DECEASED'S CEMETERY (None)		27. SIGNATURE OF DECEASED'S MONUMENT (None)	
28. SIGNATURE OF DECEASED'S GRAVE (None)		29. SIGNATURE OF DECEASED'S TOMB (None)		30. SIGNATURE OF DECEASED'S MONUMENT (None)	
31. SIGNATURE OF DECEASED'S BURIAL PLACE (None)		32. SIGNATURE OF DECEASED'S CEMETERY (None)		33. SIGNATURE OF DECEASED'S MONUMENT (None)	
34. SIGNATURE OF DECEASED'S GRAVE (None)		35. SIGNATURE OF DECEASED'S TOMB (None)		36. SIGNATURE OF DECEASED'S MONUMENT (None)	
37. SIGNATURE OF DECEASED'S BURIAL PLACE (None)		38. SIGNATURE OF DECEASED'S CEMETERY (None)		39. SIGNATURE OF DECEASED'S MONUMENT (None)	
40. SIGNATURE OF DECEASED'S GRAVE (None)		41. SIGNATURE OF DECEASED'S TOMB (None)		42. SIGNATURE OF DECEASED'S MONUMENT (None)	
43. SIGNATURE OF DECEASED'S BURIAL PLACE (None)		44. SIGNATURE OF DECEASED'S CEMETERY (None)		45. SIGNATURE OF DECEASED'S MONUMENT (None)	
46. SIGNATURE OF DECEASED'S GRAVE (None)		47. SIGNATURE OF DECEASED'S TOMB (None)		48. SIGNATURE OF DECEASED'S MONUMENT (None)	
49. SIGNATURE OF DECEASED'S BURIAL PLACE (None)		50. SIGNATURE OF DECEASED'S CEMETERY (None)		51. SIGNATURE OF DECEASED'S MONUMENT (None)	
52. SIGNATURE OF DECEASED'S GRAVE (None)		53. SIGNATURE OF DECEASED'S TOMB (None)		54. SIGNATURE OF DECEASED'S MONUMENT (None)	
55. SIGNATURE OF DECEASED'S BURIAL PLACE (None)		56. SIGNATURE OF DECEASED'S CEMETERY (None)		57. SIGNATURE OF DECEASED'S MONUMENT (None)	
58. SIGNATURE OF DECEASED'S GRAVE (None)		59. SIGNATURE OF DECEASED'S TOMB (None)		60. SIGNATURE OF DECEASED'S MONUMENT (None)	
61. SIGNATURE OF DECEASED'S BURIAL PLACE (None)		62. SIGNATURE OF DECEASED'S CEMETERY (None)		63. SIGNATURE OF DECEASED'S MONUMENT (None)	
64. SIGNATURE OF DECEASED'S GRAVE (None)		65. SIGNATURE OF DECEASED'S TOMB (None)		66. SIGNATURE OF DECEASED'S MONUMENT (None)	
67. SIGNATURE OF DECEASED'S BURIAL PLACE (None)		68. SIGNATURE OF DECEASED'S CEMETERY (None)		69. SIGNATURE OF DECEASED'S MONUMENT (None)	
70. SIGNATURE OF DECEASED'S GRAVE (None)		71. SIGNATURE OF DECEASED'S TOMB (None)		72. SIGNATURE OF DECEASED'S MONUMENT (None)	
73. SIGNATURE OF DECEASED'S BURIAL PLACE (None)		74. SIGNATURE OF DECEASED'S CEMETERY (None)		75. SIGNATURE OF DECEASED'S MONUMENT (None)	
76. SIGNATURE OF DECEASED'S GRAVE (None)		77. SIGNATURE OF DECEASED'S TOMB (None)		78. SIGNATURE OF DECEASED'S MONUMENT (None)	
79. SIGNATURE OF DECEASED'S BURIAL PLACE (None)		80. SIGNATURE OF DECEASED'S CEMETERY (None)		81. SIGNATURE OF DECEASED'S MONUMENT (None)	
82. SIGNATURE OF DECEASED'S GRAVE (None)		83. SIGNATURE OF DECEASED'S TOMB (None)		84. SIGNATURE OF DECEASED'S MONUMENT (None)	
85. SIGNATURE OF DECEASED'S BURIAL PLACE (None)		86. SIGNATURE OF DECEASED'S CEMETERY (None)		87. SIGNATURE OF DECEASED'S MONUMENT (None)	
88. SIGNATURE OF DECEASED'S GRAVE (None)		89. SIGNATURE OF DECEASED'S TOMB (None)		90. SIGNATURE OF DECEASED'S MONUMENT (None)	
91. SIGNATURE OF DECEASED'S BURIAL PLACE (None)		92. SIGNATURE OF DECEASED'S CEMETERY (None)		93. SIGNATURE OF DECEASED'S MONUMENT (None)	
94. SIGNATURE OF DECEASED'S GRAVE (None)		95. SIGNATURE OF DECEASED'S TOMB (None)		96. SIGNATURE OF DECEASED'S MONUMENT (None)	
97. SIGNATURE OF DECEASED'S BURIAL PLACE (None)		98. SIGNATURE OF DECEASED'S CEMETERY (None)		99. SIGNATURE OF DECEASED'S MONUMENT (None)	
100. SIGNATURE OF DECEASED'S GRAVE (None)		101. SIGNATURE OF DECEASED'S TOMB (None)		102. SIGNATURE OF DECEASED'S MONUMENT (None)	

BUREAU Y. S.

MAR 6 1957

RECEIVED

2421 CERTIFICATE OF DEATH

02415

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
c. LENGTH OF STAY IN 1b 3 hrs.				d. STREET ADDRESS 106 Maple Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle LAMMERT Last LAMMERT				4. DATE OF DEATH Month 3 Day 19 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-12-1876	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman				10b. KIND OF BUSINESS OR INDUSTRY Ice Plant		11. BIRTHPLACE (State or foreign country) Eckhart, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Lammert				14. MOTHER'S MAIDEN NAME Anna Martha Braundaur			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No.				16. SOCIAL SECURITY NO. 216-05-7781		17. INFORMANT Mrs. Charles A. Wolfe, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic arteriosclerotic Cardiac-Vascular disease DUE TO (c) years.				INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from MARCH 5, 1957 , to MARCH 19, 1957 , that I last saw the deceased alive on MARCH 19, 1957 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John B. Davis, M.D.				ADDRESS (Street, city or town, state) 2 Broadway, Frostburg, Md.			
PHYSICIAN'S NAME (Type) John B. Davis, M.D.				DATE SIGNED 3/21/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-22-57		22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bessie H. Montessant				ADDRESS 25 E. Main Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 3-22-57	
				24b. REGISTRAR'S SIGNATURE Mr. Nancy N. Roe			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2422 CERTIFICATE OF DEATH

02416

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 239½ Welsh Hill				d. STREET ADDRESS 239½ Welsh Hill			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES E. BURMAN LANCASTER				4. DATE OF DEATH Month Day Year March 17, 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-9-1870	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andrew Lancaster				14. MOTHER'S MAIDEN NAME Sarah Blubaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Russell Lancaster,		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 177X DUE TO Ca Prostate C Metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 yrs - DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan , 1950, to March 17, 1957 ; that I last saw the deceased alive on March 16, 1957 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John B. Davis, M.D.				ADDRESS (Street, city or town, state) 2 Broadway, Frostburg, Md.			
DATE SIGNED 2/18/57							
PHYSICIAN'S NAME (Type) John B. Davis, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-20-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 3-20-57	
24b. REGISTRAR'S SIGNATURE Miss Nancy H. Rose							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2390 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>14 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Terra Alta</u> <u>85X-3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arch</u> Middle <u>E.</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 30-1899</u>		9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millwright</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Davis, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Lee</u>				14. MOTHER'S MAIDEN NAME <u>Cora Friend</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>232-10-1384</u>		17. INFORMANT Address <u>Memorial Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> <u>902.3</u> DUE TO <u>fractured skull.</u> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO <u>a fall from a scaffold.</u> (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or head on concrete floor. <u>On scaffold, kneeling, became over balanced, fell, struck</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>7:45 P. M. 3-20 1957</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pitt. P. G. Co.</u>		20f. (City or town) (County) (State) <u>North Branch, Allegany, Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 21 -1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-24-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Terra Alta Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Terra Alta W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fike & Watson Funeral Home, Terra Alta, W. Va.</u>				24a. REC'D BY REGISTRAR DATE <u>March 21, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Shirley R. Hardy</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH
PLACE OF DEATH

BUREAU V. 2.

MAR 22 1957

RECEIVED

2391 CERTIFICATE OF DEATH

02418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 284 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MICHAEL Middle LIPPOLD Last LIPPOLD		4. DATE OF DEATH Month MARCH Day 8 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 14, 1920
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher		12. KIND OF BUSINESS OR INDUSTRY Ship Yards	
13. BIRTHPLACE (State or foreign country) WEST VIRGINIA		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME JOHN LIPPOLD		16. MOTHER'S MAIDEN NAME THERESA Maletick	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. 705-12-4675	
19. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Cecum with 153X DUE TO generalized abdominal metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 years (c) 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 28, 1956 to March 8, 1957 , that I last saw the deceased alive on March 8, 1957 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.M. Faw, Jr.		DATE SIGNED March 9, 1957	
PHYSICIAN'S NAME (Type) GEORGE X X SIMONS, M.D.		W.M. FAW, JR.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 12, 1957	22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.		24. REC'D BY REGISTRAR March 9, 1957	
24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 13 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2423 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02419

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Halethorpe #27 03-51-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Durst Funeral Home				d. STREET ADDRESS 1607 Potomac St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Earnest Last Longstreth				4. DATE OF DEATH Month March Day 22 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25-1907		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Stock Dept. - Washington Aluminum		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.		11. BIRTHPLACE (State or foreign country) Littleton, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac N. Longstreth				14. MOTHER'S MAIDEN NAME Samanthia Booth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 233-18-5603		17. INFORMANT Address (wife) Mrs. W. E. Longstreth, Halethorpe, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intrathoracic hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed chest DUE TO (c) Auto accident.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 816X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Crossed over medial line & hit another car head on.					
20c. TIME OF INJURY Month, Day, Year 8:55 a.m. 3-22 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway #40		20f. (City or town) (County) (State) Guntertown Garrett Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 23-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3-25-1957		22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Washington Blvd. Rt. #1 Md.	
23. BURIAL DIRECTOR'S SIGNATURE Ambrose Funeral Home, Annapolis, Md.				24a. REC'D BY REGISTRAR DATE 3-25-57		24b. REGISTRAR'S SIGNATURE Mr. Nancy A. R...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 1 1957

RECEIVED

2424

CERTIFICATE OF DEATH

02420

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 1 wk.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. STREET ADDRESS 44 Centennial St.			
3. NAME OF DECEASED (Type or print) First Donna Middle Jean Last Lucas				4. DATE OF DEATH Month March Day 24 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-22-39	
9. AGE (In years last birthday) 17 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George Lucas				14. MOTHER'S MAIDEN NAME Bernice Gibson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none				16. SOCIAL SECURITY NO. none		17. INFORMANT George Lucas, Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Congestive Failure DUE TO 415X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Myocarditis + Valvulitis DUE TO 14 yrs (c) Acute Rheumatic Fever 14 yrs.							INTERVAL BETWEEN ONSET AND DEATH 3 wks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 3/17 , 19 57 , to 3/24 , 19 57 , that I last saw the deceased alive on 3/23 , 19 57 , and that death occurred at 12:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank T. Harrat M.D.				ADDRESS (Street, city or town, state) 26 Mechanic St			
PHYSICIAN'S NAME (Type) FRANK T. HARRAT MD				DATE SIGNED Frostburg, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 3-26-57	
				24b. REGISTRAR'S SIGNATURE Mr. Nancy R. Rose			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		45		1880		Baltimore		Maryland		United States		America	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Carpenter		Heart Disease		Natural		April 1, 1937		Baltimore		Maryland		United States		America	
FATHER		MOTHER		SPOUSE		CHILDREN		GRANDCHILDREN		SIBLINGS		OTHER RELATIVES		OTHER	
James H. Harris		Mary H. Harris		Elizabeth Harris		John Harris, Mary Harris, William Harris		Robert Harris, Charles Harris		Thomas Harris, David Harris		Elizabeth Harris, Susan Harris		None	
EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT		HAIR		EYES	
High School		Roman Catholic		White		White		5' 8"		150 lbs		Brown		Blue	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISON		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
None		None		None		None		None		None		None		None	
PREVIOUS MENTAL ILLNESS		PREVIOUS PHYSICAL ILLNESS		PREVIOUS SURGICAL ILLNESS		PREVIOUS TRAUMATIC ILLNESS		PREVIOUS TOXIC ILLNESS		PREVIOUS INFECTIOUS ILLNESS		PREVIOUS CHRONIC ILLNESS		PREVIOUS ACUTE ILLNESS	
None		None		None		None		None		None		None		None	
PREVIOUS DEATH		PREVIOUS BURIAL		PREVIOUS CREMATION		PREVIOUS ANATOMY		PREVIOUS OTHER		PREVIOUS OTHER		PREVIOUS OTHER		PREVIOUS OTHER	
None		None		None		None		None		None		None		None	

BUREAU V. S.

APR 1 1937

RECEIVED

2392 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIAS Middle MARTENEY Last MARTENEY				4. DATE OF DEATH Month MARCH Day 2 Year 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 13, 1880		9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer Own Farm			11. BIRTHPLACE (State or foreign country) MEYERSDALE, PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME SIMON MARTENEY			14. MOTHER'S MAIDEN NAME ELIZABETH FIKE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 190-26-0467		17. INFORMANT Address Memorial Hospital Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) DIABETES MELLITUS DUE TO (c) HYPERTENSIVE ARTERIOSCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH 1/2 HOUR 4 YEARS 5 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Cataract Extraction Feb 28, 1957							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from NOV , 19 56 , to MAR 2 , 19 57 , that I last saw the deceased alive on MAR 1 , 19 57 , and that death occurred at 7:14 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Emmett L. Jones M.D. Cumberland, Md. PHYSICIAN'S NAME (Type) E EMMETT L. JONES							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/57		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Meyersdale, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. R. Konhaus				ADDRESS Meyersdale, Penna.		24a. REC'D BY REGISTRAR March 2, 1957	
				24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2393 CERTIFICATE OF DEATH

02422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALLEGANY CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 1 APT. 3F, BANNEKER APTS., FREDERICK ST.	
3. NAME OF DECEASED (Type or print) First MARION Middle Frances Last MATTHEWS		4. DATE OF DEATH Month MARCH Day 18 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/23/1906
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 18 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ERNEST COMBS		14. MOTHER'S MAIDEN NAME MAGGIE BROMERY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES., CITY		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Resected Cerebral Vascular Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 1954, to MARCH , 1957, that I last saw the deceased alive on MARCH 17 , 1957, and that death occurred at 4:05 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. O. Himmelwright		M.D. 133 Virginia Ave., Cumberland, Md DATE SIGNED 3/18/57	
PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/21/57	Rose Hill Cem	Cumberland Md.
23. FUNERAL DIRECTOR'S SIGNATURE		24. REC'D BY REGISTRAR	
Louis Stein Inc.		March 19, 1957	
ADDRESS Cumt. Md.		24b. REGISTRAR'S SIGNATURE W. H. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

<p>NAME OF DECEASED JULIA M. JONES</p>		<p>DATE OF BIRTH JULY 10, 1890</p>		<p>PLACE OF BIRTH BALTIMORE, MARYLAND</p>	
<p>DATE OF DEATH JULY 10, 1957</p>		<p>TIME OF DEATH 10:00 A.M.</p>		<p>PLACE OF DEATH BALTIMORE, MARYLAND</p>	
<p>CAUSE OF DEATH HEART DISEASE</p>		<p>IMMEDIATE CAUSE CORONARY THROMBOSIS</p>		<p>UNDERLYING CAUSE HYPERTENSION</p>	
<p>DECEASED'S SEX FEMALE</p>		<p>DECEASED'S AGE 67</p>		<p>DECEASED'S OCCUPATION HOUSEWIFE</p>	
<p>DECEASED'S MARITAL STATUS MARRIED</p>		<p>DECEASED'S EDUCATION HIGH SCHOOL</p>		<p>DECEASED'S RELIGION METHODIST</p>	
<p>DECEASED'S RACE WHITE</p>		<p>DECEASED'S COLOR WHITE</p>		<p>DECEASED'S COMPLEXION FAIR</p>	
<p>DECEASED'S BUILD MEDIUM</p>		<p>DECEASED'S HAIR GRAY</p>		<p>DECEASED'S EYES BLUE</p>	
<p>DECEASED'S MOUTH NORMAL</p>		<p>DECEASED'S THROAT NORMAL</p>		<p>DECEASED'S LUNGS NORMAL</p>	
<p>DECEASED'S STOMACH NORMAL</p>		<p>DECEASED'S LIVER NORMAL</p>		<p>DECEASED'S SPLEEN NORMAL</p>	
<p>DECEASED'S PANCREAS NORMAL</p>		<p>DECEASED'S BILIRUBIN NORMAL</p>		<p>DECEASED'S URIC ACID NORMAL</p>	
<p>DECEASED'S BLOOD NORMAL</p>		<p>DECEASED'S URINE NORMAL</p>		<p>DECEASED'S FECES NORMAL</p>	
<p>DECEASED'S SWEAT NORMAL</p>		<p>DECEASED'S TISSUES NORMAL</p>		<p>DECEASED'S SKIN NORMAL</p>	
<p>DECEASED'S NAILS NORMAL</p>		<p>DECEASED'S TEETH NORMAL</p>		<p>DECEASED'S EARS NORMAL</p>	
<p>DECEASED'S NOSE NORMAL</p>		<p>DECEASED'S MOUTH NORMAL</p>		<p>DECEASED'S THROAT NORMAL</p>	
<p>DECEASED'S LUNGS NORMAL</p>		<p>DECEASED'S LIVER NORMAL</p>		<p>DECEASED'S SPLEEN NORMAL</p>	
<p>DECEASED'S PANCREAS NORMAL</p>		<p>DECEASED'S BILIRUBIN NORMAL</p>		<p>DECEASED'S URIC ACID NORMAL</p>	
<p>DECEASED'S BLOOD NORMAL</p>		<p>DECEASED'S URINE NORMAL</p>		<p>DECEASED'S FECES NORMAL</p>	
<p>DECEASED'S SWEAT NORMAL</p>		<p>DECEASED'S TISSUES NORMAL</p>		<p>DECEASED'S SKIN NORMAL</p>	
<p>DECEASED'S NAILS NORMAL</p>		<p>DECEASED'S TEETH NORMAL</p>		<p>DECEASED'S EARS NORMAL</p>	
<p>DECEASED'S NOSE NORMAL</p>		<p>DECEASED'S MOUTH NORMAL</p>		<p>DECEASED'S THROAT NORMAL</p>	

RECEIVED
MAR 21 1957
BUREAU V. 2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02423	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 4	
Item 7 FilmG212 3-15-57 et											
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>					c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Olympia Hotel</u>					d. STREET ADDRESS <u>Olympia Hotel</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Urban</u> Last <u>McKenzie</u>					4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>19 57</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 19-1882</u>		9. AGE (in years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Avilton, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>(?) U.S.A.</u>			
13. FATHER'S NAME <u>John McKenzie</u>					14. MOTHER'S MAIDEN NAME <u>Harriett Layman</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>213-12-9195</u>		17. INFORMANT Address <u>Papers found in his room & Welfare</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause lost. DUE TO <u>Malnutrition</u>										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 6-1957</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>March 8, 1957</u>		<u>Allegany County Cem.</u>				<u>Cumberland</u> <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis Stein Inc. Cumb. MD</u>					ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>March 9, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz M.D.</u>		

MASSACHUSETTS DEPARTMENT OF HEALTH-BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER		13. DATE OF EXAMINATION		14. CITY AND STATE		15. COUNTY		16. DISTRICT		17. TOWN		18. PARISH		19. CHURCH		20. GRAVE		21. BURIAL		22. OTHER		23. REMARKS		24. SIGNATURE OF WITNESS		25. DATE OF WITNESS		26. CITY AND STATE		27. COUNTY		28. DISTRICT		29. TOWN		30. PARISH		31. CHURCH		32. GRAVE		33. BURIAL		34. OTHER		35. REMARKS		36. SIGNATURE OF WITNESS		37. DATE OF WITNESS		38. CITY AND STATE		39. COUNTY		40. DISTRICT		41. TOWN		42. PARISH		43. CHURCH		44. GRAVE		45. BURIAL		46. OTHER		47. REMARKS		48. SIGNATURE OF WITNESS		49. DATE OF WITNESS		50. CITY AND STATE		51. COUNTY		52. DISTRICT		53. TOWN		54. PARISH		55. CHURCH		56. GRAVE		57. BURIAL		58. OTHER		59. REMARKS		60. SIGNATURE OF WITNESS		61. DATE OF WITNESS		62. CITY AND STATE		63. COUNTY		64. DISTRICT		65. TOWN		66. PARISH		67. CHURCH		68. GRAVE		69. BURIAL		70. OTHER		71. REMARKS		72. SIGNATURE OF WITNESS		73. DATE OF WITNESS		74. CITY AND STATE		75. COUNTY		76. DISTRICT		77. TOWN		78. PARISH		79. CHURCH		80. GRAVE		81. BURIAL		82. OTHER		83. REMARKS		84. SIGNATURE OF WITNESS		85. DATE OF WITNESS		86. CITY AND STATE		87. COUNTY		88. DISTRICT		89. TOWN		90. PARISH		91. CHURCH		92. GRAVE		93. BURIAL		94. OTHER		95. REMARKS		96. SIGNATURE OF WITNESS		97. DATE OF WITNESS		98. CITY AND STATE		99. COUNTY		100. DISTRICT		101. TOWN		102. PARISH		103. CHURCH		104. GRAVE		105. BURIAL		106. OTHER		107. REMARKS		108. SIGNATURE OF WITNESS		109. DATE OF WITNESS		110. CITY AND STATE		111. COUNTY		112. DISTRICT		113. TOWN		114. PARISH		115. CHURCH		116. GRAVE		117. BURIAL		118. OTHER		119. REMARKS		120. SIGNATURE OF WITNESS		121. DATE OF WITNESS		122. CITY AND STATE		123. COUNTY		124. DISTRICT		125. TOWN		126. PARISH		127. CHURCH		128. GRAVE		129. BURIAL		130. OTHER		131. REMARKS		132. SIGNATURE OF WITNESS		133. DATE OF WITNESS		134. CITY AND STATE		135. COUNTY		136. DISTRICT		137. TOWN		138. PARISH		139. CHURCH		140. GRAVE		141. BURIAL		142. OTHER		143. REMARKS		144. SIGNATURE OF WITNESS		145. DATE OF WITNESS		146. CITY AND STATE		147. COUNTY		148. DISTRICT		149. TOWN		150. PARISH		151. CHURCH		152. GRAVE		153. BURIAL		154. OTHER		155. REMARKS		156. SIGNATURE OF WITNESS		157. DATE OF WITNESS		158. CITY AND STATE		159. COUNTY		160. DISTRICT		161. TOWN		162. PARISH		163. CHURCH		164. GRAVE		165. BURIAL		166. OTHER		167. REMARKS		168. SIGNATURE OF WITNESS		169. DATE OF WITNESS		170. CITY AND STATE		171. COUNTY		172. DISTRICT		173. TOWN		174. PARISH		175. CHURCH		176. GRAVE		177. BURIAL		178. OTHER		179. REMARKS		180. SIGNATURE OF WITNESS		181. DATE OF WITNESS		182. CITY AND STATE		183. COUNTY		184. DISTRICT		185. TOWN		186. PARISH		187. CHURCH		188. GRAVE		189. BURIAL		190. OTHER		191. REMARKS		192. SIGNATURE OF WITNESS		193. DATE OF WITNESS		194. CITY AND STATE		195. COUNTY		196. DISTRICT		197. TOWN		198. PARISH		199. CHURCH		200. GRAVE		201. BURIAL		202. OTHER		203. REMARKS		204. SIGNATURE OF WITNESS		205. DATE OF WITNESS		206. CITY AND STATE		207. COUNTY		208. DISTRICT		209. TOWN		210. PARISH		211. CHURCH		212. GRAVE		213. BURIAL		214. OTHER		215. REMARKS		216. SIGNATURE OF WITNESS		217. DATE OF WITNESS		218. CITY AND STATE		219. COUNTY		220. DISTRICT		221. TOWN		222. PARISH		223. CHURCH		224. GRAVE		225. BURIAL		226. OTHER		227. REMARKS		228. SIGNATURE OF WITNESS		229. DATE OF WITNESS		230. CITY AND STATE		231. COUNTY		232. DISTRICT		233. TOWN		234. PARISH		235. CHURCH		236. GRAVE		237. BURIAL		238. OTHER		239. REMARKS		240. SIGNATURE OF WITNESS		241. DATE OF WITNESS		242. CITY AND STATE		243. COUNTY		244. DISTRICT		245. TOWN		246. PARISH		247. CHURCH		248. GRAVE		249. BURIAL		250. OTHER		251. REMARKS		252. SIGNATURE OF WITNESS		253. DATE OF WITNESS		254. CITY AND STATE		255. COUNTY		256. DISTRICT		257. TOWN		258. PARISH		259. CHURCH		260. GRAVE		261. BURIAL		262. OTHER		263. REMARKS		264. SIGNATURE OF WITNESS		265. DATE OF WITNESS		266. CITY AND STATE		267. COUNTY		268. DISTRICT		269. TOWN		270. PARISH		271. CHURCH		272. GRAVE		273. BURIAL		274. OTHER		275. REMARKS		276. SIGNATURE OF WITNESS		277. DATE OF WITNESS		278. CITY AND STATE		279. COUNTY		280. DISTRICT		281. TOWN		282. PARISH		283. CHURCH		284. GRAVE		285. BURIAL		286. OTHER		287. REMARKS		288. SIGNATURE OF WITNESS		289. DATE OF WITNESS		290. CITY AND STATE		291. COUNTY		292. DISTRICT		293. TOWN		294. PARISH		295. CHURCH		296. GRAVE		297. BURIAL		298. OTHER		299. REMARKS		300. SIGNATURE OF WITNESS		301. DATE OF WITNESS		302. CITY AND STATE		303. COUNTY		304. DISTRICT		305. TOWN		306. PARISH		307. CHURCH		308. GRAVE		309. BURIAL		310. OTHER		311. REMARKS		312. SIGNATURE OF WITNESS		313. DATE OF WITNESS		314. CITY AND STATE		315. COUNTY		316. DISTRICT		317. TOWN		318. PARISH		319. CHURCH		320. GRAVE		321. BURIAL		322. OTHER		323. REMARKS		324. SIGNATURE OF WITNESS		325. DATE OF WITNESS		326. CITY AND STATE		327. COUNTY		328. DISTRICT		329. TOWN		330. PARISH		331. CHURCH		332. GRAVE		333. BURIAL		334. OTHER		335. REMARKS		336. SIGNATURE OF WITNESS		337. DATE OF WITNESS		338. CITY AND STATE		339. COUNTY		340. DISTRICT		341. TOWN		342. PARISH		343. CHURCH		344. GRAVE		345. BURIAL		346. OTHER		347. REMARKS		348. SIGNATURE OF WITNESS		349. DATE OF WITNESS		350. CITY AND STATE		351. COUNTY		352. DISTRICT		353. TOWN		354. PARISH		355. CHURCH		356. GRAVE		357. BURIAL		358. OTHER		359. REMARKS		360. SIGNATURE OF WITNESS		361. DATE OF WITNESS		362. CITY AND STATE		363. COUNTY		364. DISTRICT		365. TOWN		366. PARISH		367. CHURCH		368. GRAVE		369. BURIAL		370. OTHER		371. REMARKS		372. SIGNATURE OF WITNESS		373. DATE OF WITNESS		374. CITY AND STATE		375. COUNTY		376. DISTRICT		377. TOWN		378. PARISH		379. CHURCH		380. GRAVE		381. BURIAL		382. OTHER		383. REMARKS		384. SIGNATURE OF WITNESS		385. DATE OF WITNESS		386. CITY AND STATE		387. COUNTY		388. DISTRICT		389. TOWN		390. PARISH		391. CHURCH		392. GRAVE		393. BURIAL		394. OTHER		395. REMARKS		396. SIGNATURE OF WITNESS		397. DATE OF WITNESS		398. CITY AND STATE		399. COUNTY		400. DISTRICT		401. TOWN		402. PARISH		403. CHURCH		404. GRAVE		405. BURIAL		406. OTHER		407. REMARKS		408. SIGNATURE OF WITNESS		409. DATE OF WITNESS		410. CITY AND STATE		411. COUNTY		412. DISTRICT		413. TOWN		414. PARISH		415. CHURCH		416. GRAVE		417. BURIAL		418. OTHER		419. REMARKS		420. SIGNATURE OF WITNESS		421. DATE OF WITNESS		422. CITY AND STATE		423. COUNTY		424. DISTRICT		425. TOWN		426. PARISH		427. CHURCH		428. GRAVE		429. BURIAL		430. OTHER		431. REMARKS		432. SIGNATURE OF WITNESS		433. DATE OF WITNESS		434. CITY AND STATE		435. COUNTY		436. DISTRICT		437. TOWN		438. PARISH		439. CHURCH		440. GRAVE		441. BURIAL		442. OTHER		443. REMARKS		444. SIGNATURE OF WITNESS		445. DATE OF WITNESS		446. CITY AND STATE		447. COUNTY		448. DISTRICT		449. TOWN		450. PARISH		451. CHURCH		452. GRAVE		453. BURIAL		454. OTHER		455. REMARKS		456. SIGNATURE OF WITNESS		457. DATE OF WITNESS		458. CITY AND STATE		459. COUNTY		460. DISTRICT		461. TOWN		462. PARISH		463. CHURCH		464. GRAVE		465. BURIAL		466. OTHER		467. REMARKS		468. SIGNATURE OF WITNESS		469. DATE OF WITNESS		470. CITY AND STATE		471. COUNTY		472. DISTRICT		473. TOWN		474. PARISH		475. CHURCH		476. GRAVE		477. BURIAL		478. OTHER		479. REMARKS		480. SIGNATURE OF WITNESS		481. DATE OF WITNESS		482. CITY AND STATE		483. COUNTY		484. DISTRICT		485. TOWN		486. PARISH		487. CHURCH		488. GRAVE		489. BURIAL		490. OTHER		491. REMARKS		492. SIGNATURE OF WITNESS		493. DATE OF WITNESS		494. CITY AND STATE		495. COUNTY		496. DISTRICT		497. TOWN		498. PARISH		499. CHURCH		500. GRAVE		501. BURIAL		502. OTHER		503. REMARKS		504. SIGNATURE OF WITNESS		505. DATE OF WITNESS		506. CITY AND STATE		507. COUNTY		508. DISTRICT		509. TOWN		510. PARISH		511. CHURCH		512. GRAVE		513. BURIAL		514. OTHER		515. REMARKS		516. SIGNATURE OF WITNESS		517. DATE OF WITNESS		518. CITY AND STATE		519. COUNTY		520. DISTRICT		521. TOWN		522. PARISH		523. CHURCH		524. GRAVE		525. BURIAL		526. OTHER		527. REMARKS		528. SIGNATURE OF WITNESS		529. DATE OF WITNESS		530. CITY AND STATE		531. COUNTY		532. DISTRICT		533. TOWN		534. PARISH		535. CHURCH		536. GRAVE		537. BURIAL		538. OTHER		539. REMARKS		540. SIGNATURE OF WITNESS		541. DATE OF WITNESS		542. CITY AND STATE		543. COUNTY		544. DISTRICT		545. TOWN		546. PARISH		547. CHURCH		548. GRAVE		549. BURIAL		550. OTHER		551. REMARKS		552. SIGNATURE OF WITNESS		553. DATE OF WITNESS		554. CITY AND STATE		555. COUNTY		556. DISTRICT		557. TOWN		558. PARISH		559. CHURCH		560. GRAVE		561. BURIAL		562. OTHER		563. REMARKS		564. SIGNATURE OF WITNESS		565. DATE OF WITNESS		566. CITY AND STATE		567. COUNTY		568. DISTRICT		569. TOWN		570. PARISH		571. CHURCH		572. GRAVE		573. BURIAL		574. OTHER		575. REMARKS		576. SIGNATURE OF WITNESS		577. DATE OF WITNESS		578. CITY AND STATE		579. COUNTY		580. DISTRICT		581. TOWN		582. PARISH		583. CHURCH		584. GRAVE		585. BURIAL		586. OTHER		587. REMARKS		588. SIGNATURE OF WITNESS		589. DATE OF WITNESS		590. CITY AND STATE		591. COUNTY		592. DISTRICT		593. TOWN		594. PARISH		595. CHURCH		596. GRAVE		597. BURIAL		598. OTHER		599. REMARKS		600. SIGNATURE OF WITNESS		601. DATE OF WITNESS		602. CITY AND STATE		603. COUNTY		604. DISTRICT		605. TOWN		606. PARISH		607. CHURCH		608. GRAVE		609. BURIAL		610. OTHER		611. REMARKS		612. SIGNATURE OF WITNESS		613. DATE OF WITNESS		614. CITY AND STATE		615. COUNTY		616. DISTRICT		617. TOWN		618. PARISH		619. CHURCH		620. GRAVE		621. BURIAL		622. OTHER		623. REMARKS		624. SIGNATURE OF WITNESS		625. DATE OF WITNESS		626. CITY AND STATE		627. COUNTY		628. DISTRICT		629. TOWN		630. PARISH		631. CHURCH		632. GRAVE		633. BURIAL		634. OTHER		635. REMARKS		636. SIGNATURE OF WITNESS		637. DATE OF WITNESS		638. CITY AND STATE		639. COUNTY		640. DISTRICT		641. TOWN		642. PARISH		643. CHURCH		644. GRAVE		645. BURIAL		646. OTHER		647. REMARKS		648. SIGNATURE OF WITNESS		649. DATE OF WITNESS		650. CITY AND STATE		651. COUNTY		652. DISTRICT		653. TOWN		654. PARISH		655. CHURCH		656. GRAVE		657. BURIAL		658. OTHER		659. REMARKS		660. SIGNATURE OF WITNESS		661. DATE OF WITNESS		662. CITY AND STATE		663. COUNTY		664. DISTRICT		665. TOWN		666. PARISH		667. CHURCH		668. GRAVE		669. BURIAL		670. OTHER		671. REMARKS		672. SIGNATURE OF WITNESS		673. DATE OF WITNESS		674. CITY AND STATE		675. COUNTY		676. DISTRICT		677. TOWN		678. PARISH		679. CHURCH		680. GRAVE		681. BURIAL		682. OTHER		683. REMARKS		684. SIGNATURE OF WITNESS		685. DATE OF WITNESS		686. CITY AND STATE		687. COUNTY		688. DISTRICT		689. TOWN		690. PARISH		691. CHURCH		692. GRAVE		693. BURIAL		694. OTHER		695. REMARKS		696. SIGNATURE OF WITNESS		697. DATE OF WITNESS		698. CITY AND STATE		699. COUNTY		700. DISTRICT		701. TOWN		702. PARISH		703. CHURCH		704. GRAVE		705. BURIAL		706. OTHER		707. REMARKS		708. SIGNATURE OF WITNESS		709. DATE OF WITNESS		710. CITY AND STATE		711. COUNTY		712. DISTRICT		713. TOWN		714. PARISH		715. CHURCH		716. GRAVE		717. BURIAL		718. OTHER		719. REMARKS		720. SIGNATURE OF WITNESS		721. DATE OF WITNESS		722. CITY AND STATE		723. COUNTY		724. DISTRICT		725. TOWN		726. PARISH		727. CHURCH		728. GRAVE		729. BURIAL		730. OTHER		731. REMARKS		732. SIGNATURE OF WITNESS		733. DATE OF WITNESS		734. CITY AND STATE		735. COUNTY		736. DISTRICT		737. TOWN		738. PARISH		739. CHURCH		740. GRAVE		741. BURIAL		742. OTHER		743. REMARKS		744. SIGNATURE OF WITNESS		745. DATE OF WITNESS		746. CITY AND STATE		747. COUNTY		748. DISTRICT		749. TOWN		750. PARISH		751. CHURCH		752. GRAVE		753. BURIAL		754. OTHER		755. REMARKS		756. SIGNATURE OF WITNESS		757. DATE OF WITNESS		758. CITY AND STATE		759. COUNTY		760. DISTRICT		761. TOWN		762. PARISH		763. CHURCH		764. GRAVE		765. BURIAL		766. OTHER		767. REMARKS		768. SIGNATURE OF WITNESS		769. DATE OF WITNESS		770. CITY AND STATE		771. COUNTY		772. DISTRICT		773. TOWN		774. PARISH		775. CHURCH		776. GRAVE		777. BURIAL		778. OTHER		779. REMARKS		780. SIGNATURE OF WITNESS		781. DATE OF WITNESS		782. CITY AND STATE		783. COUNTY		784. DISTRICT		785. TOWN		786. PARISH		787. CHURCH		788. GRAVE		789. BURIAL		790. OTHER			
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2425 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN life 22 Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 138 Bowery St.				d. STREET ADDRESS 1 138 Bowery St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) GEORGE WILLIAMSON McLUCKIE				4. DATE OF DEATH March 9, 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR: Months 66 Days 66 Hours 66 Min. 66		IF UNDER 24 HRS. 66			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired engineer				10b. KIND OF BUSINESS OR INDUSTRY State T. College		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Alexander McLuckie				14. MOTHER'S MAIDEN NAME Mary Williamson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs. Mary McLuckie,				Address Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac dilatation 422.2 DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) Chronic myocarditis						INTERVAL BETWEEN ONSET AND DEATH 14 yrs. 7-8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3-8 , 19 57 , to 3-9 , 19 57 , that I last saw the deceased alive on 3-9 , 19 57 , and that death occurred at 3 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H.C. Diehl M.D.				ADDRESS (Street, city or town, state) Frostburg, Md.			
DATE SIGNED 3/9/57							
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-11-1957		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.			
24a. REC'D BY REGISTRAR DATE 3-11-57				24b. REGISTRAR'S SIGNATURE Wm. Nancy H. Roe			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered to the funeral director for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

RECEIVED

1
Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SARATOGA COUNTY DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 FilmG212 3-20-57 et

02425

2395 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 14 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ASA Middle MILLER Last MILLER		4. DATE OF DEATH Month MARCH Day 11 Year 1957	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 10, 1869
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter	
11. BIRTHPLACE (State or foreign country) PENNA. Bedford Co.,		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME BARKLEY MILLER		14. MOTHER'S MAIDEN NAME Lucinda Linn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Amy Miller 930 Glenwood St., Cumb. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anuria 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia DUE TO (c) Myocardial fibrosis with myocardial decompensation		INTERVAL BETWEEN ONSET AND DEATH 3 days 14 days 2/??	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Fibrosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 25 1957 , to March 11 1957 , that I last saw the deceased alive on March 11, 1957 , and that death occurred at 9:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 50 Pershing Street, Cumberland, Md. DATE SIGNED 3-11-57			
ACTUAL SIGNATURE Samuel M. Jacobson		PHYSICIAN'S NAME (Type) Samuel M. Jacobson M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/57	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Fairview, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR March 13, 1957		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

(Continued)

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1993, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 26

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BUREAU V. 8.

443-15-1957

RECEIVED

CERTIFICATE OF DEATH

Register No.

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
JAMES H. HARRIS		Male		45		1912		BALTIMORE, MARYLAND	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		None	
Date of Death		Place of Death		Physician		Hospital		Burial Place	
March 28, 1957		Home		J. H. Smith, M.D.		None		None	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Medical Examiner	
J. H. Smith, M.D.		None		None		None		None	

RECEIVED
MAR 29 1957
BUREAU V. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gilmore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Gilmore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) #1 Frostburg, Md.		e. STREET ADDRESS R.F.D. #1 Frostburg, Md.	
3. NAME OF DECEASED (Type or print) Francis First H. Middle Moore Last		4. DATE OF DEATH March Month 28 Day 19 57 Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1-1895
9. AGE (In years last birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker-Kelley-Springfield Tire Co. Gilmore, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Moore		14. MOTHER'S MAIDEN NAME Jean Harper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W.1		16. SOCIAL SECURITY NO. 214-07-1134	
17. INFORMANT Address (wife) Eleanor Moore, Gilmore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH sudden ? </div> </div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		DATE SIGNED March 28-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-30-57	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Monticant		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE 3-30-57	

MASS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED</p>		<p>DATE OF DEATH</p>	
<p>AGE</p>		<p>SEX</p>	
<p>DATE OF BIRTH</p>		<p>PLACE OF BIRTH</p>	
<p>EDUCATION</p>		<p>OCCUPATION</p>	
<p>RELIGION</p>		<p>USUAL RESIDENCE</p>	
<p>PRESENT RESIDENCE</p>		<p>CAUSE OF DEATH</p>	
<p>IMMEDIATE CAUSE OF DEATH</p>		<p>UNDERLYING CAUSE OF DEATH</p>	
<p>DATE OF EXAMINATION</p>		<p>PLACE OF EXAMINATION</p>	
<p>EXAMINER'S SIGNATURE</p>		<p>DATE OF SIGNATURE</p>	
<p>WITNESSES' SIGNATURES</p>		<p>DATE OF SIGNATURES</p>	
<p>NOTARY PUBLIC'S SIGNATURE</p>		<p>DATE OF SIGNATURE</p>	
<p>NOTARY PUBLIC'S COMMISSION EXPIRATION DATE</p>		<p>NOTARY PUBLIC'S OFFICE</p>	

BUREAU V. S.

APR 3 1957

RECEIVED

2426 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 28 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 252 Center Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle William Last Morgan				4. DATE OF DEATH Month March Day 14 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 3, 1897	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY P.P.G Co.	
11. BIRTHPLACE (State or foreign country) Moscow, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Morgan				14. MOTHER'S MAIDEN NAME Jane Knapp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-09-7963		17. INFORMANT Stanley Morgan Address Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardiac Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs. over 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frostburg				20g. (County) Allegany		20h. (State) Md.	
21. I certify that I attended the deceased from 3/11/57 , 19 57 , to 3/14/57 , 19 57 , that I last saw the deceased alive on 3/14/57 , and that death occurred at 12 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 2 BROADWAY				DATE SIGNED 3/15/57			
ACTUAL SIGNATURE John B. Davis, M.D.							
PHYSICIAN'S NAME (Type) John B. Davis, M.D. Frostburg Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/17/57		22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE 3-18-57	
				24b. REGISTRAR'S SIGNATURE Wm. Harvey N. Roe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2397 CERTIFICATE OF DEATH

Reg. Dist. No.

02429

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		d. STREET ADDRESS <u>885 Patterson Ave., etc.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mike</u> Middle <u>Morick</u> Last <u>Morick</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired carpenter</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Tire Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Yugoslavia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-07-0315</u>		17. INFORMANT <u>Mrs. Mary Morick 885 Patterson Ave., Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of penis</u> <u>179X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>8 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-27</u> , 19 <u>57</u> , to <u>3-2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-2</u> , 19 <u>57</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph W. Ballin</u>		ADDRESS (Street, city or town, state) <u>62 Greene St.</u>	
PHYSICIAN'S NAME (Type) <u>Ralph W. Ballin, M.D.</u>		DATE SIGNED <u>3-4-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Maryland</u>	
24a. REC'D BY REGISTRAR <u>March 4, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz, M.D.</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02430
41
Within corporate limits

DR. HIMMELWRIGHT

2398 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS E. MORRISON				4. DATE OF DEATH Month Day Year MARCH 7 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 21, 1980	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Laborer Railroad		10b. KIND OF BUSINESS OR INDUSTRY Burlington WEST VIRGINIA		9. AGE (In years lost birthday) yrs. 77		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W. MORRISON				14. MOTHER'S MAIDEN NAME Hanna Newcomb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-09-9915		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X 17 denovo cessation of ascending colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 months						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug , 19 56 , to March , 19 57 , that I last saw the deceased alive on March 7 , 19 57 , and that death occurred at 4:06 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Himmelwright				ADDRESS (Street, city or town, state) DATE SIGNED 133 Virginia Ave, Cumberland, Md 3/8/57			
PHYSICIAN'S NAME (Type) G. Overton Himmelwright							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-10-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 9, 1957	
				24b. REGISTRAR'S SIGNATURE W. K. Frantz, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN V. KERRICK		AGE 65		SEX MALE		RACE WHITE		DATE OF BIRTH APR 15 1892	
PLACE OF BIRTH BALTIMORE, MARYLAND		OCCUPATION RETIRED		EDUCATION HIGH SCHOOL		RELIGION METHODIST		MARRIAGE MARRIED	
DATE OF DEATH MAY 10 1957		PLACE OF DEATH BALTIMORE, MARYLAND		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		SIGNATURE OF PHYSICIAN J. V. KERRICK	
DATE OF INTERMENT MAY 13 1957		PLACE OF INTERMENT BALTIMORE, MARYLAND		NAME OF FUNERAL HOME KERRICK FUNERAL HOME		NAME OF MINISTER J. V. KERRICK		NAME OF CLERGYMAN J. V. KERRICK	
DATE OF BURIAL MAY 13 1957		PLACE OF BURIAL BALTIMORE, MARYLAND		NAME OF BURIAL HOME KERRICK BURIAL HOME		NAME OF MINISTER J. V. KERRICK		NAME OF CLERGYMAN J. V. KERRICK	

BUREAU V. S.

MAR 13 1957

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2439 CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westernport x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 Mi. N. of Westernport		d. STREET ADDRESS R.D. 1-Westernport	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John William Paugh		4. DATE OF DEATH Mar. 11 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/28/1893
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Paugh		14. MOTHER'S MAIDEN NAME Minnie Young Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-09-0461	
17. INFORMANT Address Odis David Paugh-Westernport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Miners Asthma DUE TO (c) Myocardial Weakness		INTERVAL BETWEEN ONSET AND DEATH 3 Days 5 yrs 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/10 , 19 57 , to 3/11 , 19 57 that I last saw the deceased alive on 3/11 , 19 57 , and that death occurred at 6 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont W. Va. DATE SIGNED Piedmont W. Va.			
ACTUAL SIGNATURE P.E. Berry		M.D. Piedmont W. Va.	
PHYSICIAN'S NAME (Type) P.E. Berry			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/14/57	22c. NAME OF CEMETERY OR CREMATORY Philos Cem.	22d. LOCATION (City, town, or county) (State) Westernport Md.
23. FUNERAL DIRECTOR'S SIGNATURE E. F. Boal		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR DATE 3-13-57		24b. REGISTRAR'S SIGNATURE Jan C. Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02433

2399 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 12/21/56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle S. Last Piper				4. DATE OF DEATH Month March Day 15 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/28/1882	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Coal Miner - Mining		10b. KIND OF BUSINESS OR INDUSTRY Mining	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Lawrence O. Piper				14. MOTHER'S MAIDEN NAME Amanda King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-5485		17. INFORMANT P. O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Hemorrhage DUE TO (c) Chronic Myocarditis						INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. Month 19 Day 19 Year 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12/21/56 , 19____, to 3/15/57 , 19____, that I last saw the deceased alive on 3/15/57 , 19____, and that death occurred at 2:15 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE James E. McLean M.D.				49 Greene Street 3/15/57			
PHYSICIAN'S NAME (Type) Dr. James E. McLean, M.D.				Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/17/57		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park, Frostburg, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.			
24a. REC'D BY REGISTRAR March 16, 1957				24b. REGISTRAR'S SIGNATURE O. R. Hantz, M.D.			

CERTIFICATE OF DEATH

MAINTAIN STATE DEPARTMENT OF HEALTH - BATHING 18

Allegany County, West Virginia

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2427

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>		c. LENGTH OF STAY IN 1b <u>49 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>43 Westernport</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stoney Run Road</u>			d. STREET ADDRESS <u>Stoney Run Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Stephen</u> Middle <u>Plosz</u> Last <u>Plosz</u>			4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1957</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28-1883</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Pulp Mill laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.Va.P & P.Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Hungry</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Frank Plosz</u>			14. MOTHER'S MAIDEN NAME <u>Veronica Folde</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-09-6421</u>		17. INFORMANT <u>Memorial Hospital records & his papers.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrathoracic hemorrhage due to a 38</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>caliber revolver bullet wound in left chest</u> DUE TO (c) <u>self inflicted.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>G.U.treatments,nervous,shot himself at his home.</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>G.U.treatments,nervous,shot himself at his home.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>12-30-3-17 19 57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
		20f. (City or town) <u>Westernport</u>		(County) <u>Allegany</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 17-1957</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philby</u>	
		ADDRESS <u>Westernport, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Boral</u>		24a. REC'D BY REGISTRAR DATE <u>3-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Jean C. Kelly</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM EXAMINATION		FINDINGS		REMARKS	
EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
SOCIETY		HABITS		DIET		EXERCISE		CLOTHING		WEATHER	
TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION		HEART		LUNGS	
LIVER		SPLEEN		PANCREAS		GASTROINTESTINAL		URINARY		REPRODUCTIVE	
SKIN		MUSCLES		BONES		JOINTS		NEUROLOGICAL		PSYCHIATRIC	
TOOTH		EYE		EAR		NOSE		THROAT		LARYNX	
TRACHEA		BRONCHI		PULMONARY		PERICARDIUM		MYOCARDIUM		ENDOCARDIUM	
VALVES		CORONARY		AORTA		ABDOMEN		PELVIS		GENITALS	
VAGINA		UTERUS		OVARY		TESTIS		EPIDIDYMO		VASCULATURE	
LYMPHATIC		HISTOLOGY		MICROSCOPY		RADIOLOGY		PATHOLOGY		LABORATORY	
CHEMISTRY		PHYSIOLOGY		ANATOMY		PHARMACOLOGY		TOXICOLOGY		ANTHROPOLOGY	
SOCIOLOGY		LITERATURE		ARTS		SCIENCE		TECHNOLOGY		INSTRUMENTS	
EQUIPMENT		SUPPLIES		REAGENTS		SPECIMENS		RESULTS		DISCUSSION	
CONCLUSIONS		RECOMMENDATIONS		REFERENCES		APPENDICES		GLOSSARY		INDEX	

BUREAU V. S.

MAR 22 1957

RECEIVED

2428 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 Center St.,		e. STREET ADDRESS 108 Center St.	
3. NAME OF DECEASED (Type or print) First NELLIE Middle (LEWIS) Last PORTER		4. DATE OF DEATH Month March Day 27 , Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-1901
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John G. Lewis		14. MOTHER'S MAIDEN NAME Harriet Meyers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Dewey Porter,		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 hrs 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar 27, 1957 , to Mar 27, 1957 , that I last saw the deceased alive on Mar 27, 1957 , and that death occurred at 3:20 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W O McLane M.D.		ADDRESS (Street, city or town, state) Frostburg	
PHYSICIAN'S NAME (Type) W. O. McLane, M. D.		DATE SIGNED Mar 29 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-30-57	22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR 3-30-57		24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Ree	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED JOHN P. TAYLOR</p>		<p>2. SEX MALE</p>	
<p>3. AGE 45</p>		<p>4. DATE OF DEATH APR 3 1957</p>	
<p>5. PLACE OF DEATH HOME</p>		<p>6. CITY BALTIMORE</p>	
<p>7. COUNTY BALTIMORE</p>		<p>8. STATE MARYLAND</p>	
<p>9. OCCUPATION ENGINEER</p>		<p>10. CAUSE OF DEATH HEART DISEASE</p>	
<p>11. MANNER OF DEATH NATURAL</p>		<p>12. SIGNATURE OF PHYSICIAN J. P. TAYLOR</p>	
<p>13. SIGNATURE OF WITNESSES J. P. TAYLOR</p>		<p>14. SIGNATURE OF REGISTRAR J. P. TAYLOR</p>	

BUREAU V. S.

APR 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02436

2440

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle Ellis Last Rinard		4. DATE OF DEATH Month March Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1883
9. AGE (In years last birthday) yrs. 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bus Co. Owner	
11. BIRTHPLACE (State or foreign country) Bedford, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Sylvester Rinard		14. MOTHER'S MAIDEN NAME Mary C. Defibaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Mrs. Gilbert Wiggins		Address Moultonboro, N. H.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinomatous DUE TO Carcinoma of Stomach (c) 18 months			INTERVAL BETWEEN ONSET AND DEATH 14 days 6 months 18 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 21, 1957 , to Mar. 19, 1957 , that I last saw the deceased alive on Mar. 12, 1957 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 Virginia Ave., DATE SIGNED 3/20/57			
ACTUAL SIGNATURE Clay E. Durrett M.D.		PHYSICIAN'S NAME (Type) Clay E. Durrett M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/57	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR March 21, 1957		24b. REGISTRAR'S SIGNATURE Veronica M. Dermitt	

• 877 •

BUREAU V. 3

MAR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02437

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sylvan Retreat, Furnace St.</u>		d. STREET ADDRESS <u>? Unknown</u>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>R.</u> Last <u>Rittenour</u>		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/98</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O RR.</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Luke, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Russell Rittenour</u>		14. MOTHER'S MAIDEN NAME <u>Hedley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Sylvan Retreat</u>	
17. INFORMANT Address <u>Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hypostasis</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>Suicide psychosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Suicide psychosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1st, 1957</u> to <u>Mar. 4th, 1957</u> , that I last saw the deceased alive on <u>Mar. 4th, 1957</u> , and that death occurred at <u>5:45 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James E. McLean</u> M.D.		ADDRESS (Street, city or town, state) <u>49 Bruce St.</u> DATE SIGNED <u>3-5-57</u>	
PHYSICIAN'S NAME (Type) <u>James E. McLean, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/8/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Allegany County Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodstock, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Kight, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>March 6, 1957</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. Kight, M.D.</u>	

BUREAU V. 3

MAR 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02438

Within corporate limits

2491

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>124 Bedford St.</u>		d. STREET ADDRESS <u>124 Bedford St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>M.</u> Last <u>Robinette</u>		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Flintstone Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eli Hartsock</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Catherine Moore Cumberland Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-27</u> , 19 <u>57</u> , to <u>3/1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>57</u> , and that death occurred at <u>4:45 A.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Leo H. Ley Jr.</u> ADDRESS (Street, city or town, state) <u>456 N. Centre St.</u> DATE SIGNED <u>3/1/57</u> PHYSICIAN'S NAME (Type) <u>LEO H. LEY JR</u> <u>Cumberland, Ind</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 3, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>T.O.O.F. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Flintstone Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb Md.</u>		24a. REC'D BY REGISTRAR <u>March 2, 1957</u> 24b. REGISTRAR'S SIGNATURE <u>W.R. Granty Md.</u>	

BUREAU V. S.

MAR 6 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02439

2429 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Route 2			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle EDWARD Last ROSENBERGER				4. DATE OF DEATH Month March Day 1 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-16-1878	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired miner				10b. KIND OF BUSINESS OR INDUSTRY clay mines		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Godfrey Rosenberger				14. MOTHER'S MAIDEN NAME Margaret Bittner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-10-9890		17. INFORMANT Address Mrs. Dessie Drees, Frostburg Rt. 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular disease DUE TO 443x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility							
INTERVAL BETWEEN ONSET AND DEATH 5 years.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 2-23-1957 to 3-1-1957 , that I last saw the deceased alive on 3-1-1957 , and that death occurred at 12:30 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. C. Diehl				ADDRESS (Street, city or town, state) Frostburg, Md.			
PHYSICIAN'S NAME (Type) H. C. Diehl, M.D.				DATE SIGNED 3/2/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-4-1957		22c. NAME OF CEMETERY OR CREMATORY Finzel Cemetery		22d. LOCATION (City, town, or county) (State) Finzel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 3-4-57	
24b. REGISTRAR'S SIGNATURE Wm. H. H. H. H. H.							

BUREAU T. 2

MAR 11 1957

RECEIVED

2402 CERTIFICATE OF DEATH

Reg. Dist. No. 02440

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>			d. STREET ADDRESS <u>312 Furnace Street</u>		
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>E</u> Last <u>Ruppert</u>			4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>19 57</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-09</u>		9. AGE (In years lost birthday) <u>47</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charles Fisher</u>			14. MOTHER'S MAIDEN NAME <u>Catherine Zopf</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-24-1995</u>		17. INFORMANT <u>Patients chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Embolism</u> <u>626x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmic Abscess</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>101 W. Center St., Cumberland, Md.</u>			20g. (County) (State)		
21. I certify that I attended the deceased from <u>10/12/57</u> , 19 <u>57</u> , to <u>18 Mar 1957</u> , that I last saw the deceased alive on <u>17 Mar 1957</u> , and that death occurred at <u>4:40 AM</u> , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) DATE SIGNED <u>122 So. Center St., Cumberland, Md. 19 Mar 57</u>					
ACTUAL SIGNATURE <u>James B. Stigmauer M.D.</u>					
PHYSICIAN'S NAME (Type) <u>J.C. Stigmauer</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SS Peter & Pauls</u>	
22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u>		ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR <u>March 19, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>W.H. Frantz, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		MARRIAGE	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY AND STATE	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY	
PREVIOUS ILLNESS		TREATMENT		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF DEATH REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 3

MAR 21 1957

RECEIVED

2403 CERTIFICATE OF DEATH

Reg. Dist. No. 02441

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>D. O. A. Memorial Hospital</u>				d. STREET ADDRESS <u>126 So. Allegany St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grover Cleveland Semler</u>				4. DATE OF DEATH Month Day Year <u>March 22 19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 1, 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Jewelry Store</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>William Semler</u>			
14. MOTHER'S MAIDEN NAME <u>E. Lizer</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>219-14-7172</u>				17. INFORMANT Address <u>Mrs. Eloise Shandryk Aberdeen, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal cardiac failure</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1892</u> to <u>1952</u> , that I last saw the deceased alive on <u>1 Mar. 57</u> , 19 <u>57</u> , and that death occurred at <u>7:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7225 Gt. St. Cumberland, Md.</u> DATE SIGNED <u>27 Mar. 57</u>							
ACTUAL SIGNATURE <u>W. Alfred Van Ormer</u> M.D.				DATE SIGNED <u>27 Mar. 57</u>			
PHYSICIAN'S NAME (Type) <u>W. Alfred Van Ormer M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-25-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>March 23, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1910		BALTIMORE		MD		USA			
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED							
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
MAR 27 1957		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		HYPERTENSION		MEDICINE		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

RECEIVED
MAR 27 1957
BUREAU H H

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2430 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 59 Wright St., Grahams town		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lena Middle Sgaggero Last Sgaggero				4. DATE OF DEATH Month March Day 27 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 26, 1897	
9. AGE (In years last birthday) 60 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Yemo Lacuto			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Frank Sgaggero, Sr., 59 Wright St., Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from esophageal varices 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of liver DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 72 hrs 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 1945 to March 27, 1957 that I last saw the deceased alive on 3/27 , 19 57 , and that death occurred at 04:57 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Hilda Jane Walters M.D.				ADDRESS (Street, city or town, state) 48 Broadway Frostburg Md.			
PHYSICIAN'S NAME (Type) Hilda Jane Walters				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-30-57		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Basil H. Montsant				24a. REC'D BY REGISTRAR 23E. Main, Frostburg, Md.			
24b. REGISTRAR'S SIGNATURE DATE 3-30-57 Mrs. Nancy N. Per							

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>Baltimore, Md.</i>		5. DATE OF BIRTH <i>Jan 15, 1900</i>		6. PLACE OF DEATH <i>Baltimore, Md.</i>	
7. OCCUPATION <i>Teacher</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF CORONER <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. DATE OF DEATH <i>Apr 3, 1945</i>		14. TIME OF DEATH <i>10:00 AM</i>		15. PLACE OF BURIAL <i>St. Mary's Cemetery</i>	
16. NAME OF FUNERAL HOME <i>John Doe</i>		17. NAME OF UNDERTAKER <i>John Doe</i>		18. NAME OF CEMETERY <i>St. Mary's Cemetery</i>	
19. NAME OF MINISTER <i>John Doe</i>		20. NAME OF CHURCH <i>St. Mary's Church</i>		21. NAME OF FUNERAL HOME <i>John Doe</i>	
22. NAME OF UNDERTAKER <i>John Doe</i>		23. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		24. NAME OF FUNERAL HOME <i>John Doe</i>	
25. NAME OF MINISTER <i>John Doe</i>		26. NAME OF CHURCH <i>St. Mary's Church</i>		27. NAME OF FUNERAL HOME <i>John Doe</i>	
28. NAME OF UNDERTAKER <i>John Doe</i>		29. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		30. NAME OF FUNERAL HOME <i>John Doe</i>	
31. NAME OF MINISTER <i>John Doe</i>		32. NAME OF CHURCH <i>St. Mary's Church</i>		33. NAME OF FUNERAL HOME <i>John Doe</i>	
34. NAME OF UNDERTAKER <i>John Doe</i>		35. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		36. NAME OF FUNERAL HOME <i>John Doe</i>	
37. NAME OF MINISTER <i>John Doe</i>		38. NAME OF CHURCH <i>St. Mary's Church</i>		39. NAME OF FUNERAL HOME <i>John Doe</i>	
40. NAME OF UNDERTAKER <i>John Doe</i>		41. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		42. NAME OF FUNERAL HOME <i>John Doe</i>	
43. NAME OF MINISTER <i>John Doe</i>		44. NAME OF CHURCH <i>St. Mary's Church</i>		45. NAME OF FUNERAL HOME <i>John Doe</i>	
46. NAME OF UNDERTAKER <i>John Doe</i>		47. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		48. NAME OF FUNERAL HOME <i>John Doe</i>	
49. NAME OF MINISTER <i>John Doe</i>		50. NAME OF CHURCH <i>St. Mary's Church</i>		51. NAME OF FUNERAL HOME <i>John Doe</i>	
52. NAME OF UNDERTAKER <i>John Doe</i>		53. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		54. NAME OF FUNERAL HOME <i>John Doe</i>	
55. NAME OF MINISTER <i>John Doe</i>		56. NAME OF CHURCH <i>St. Mary's Church</i>		57. NAME OF FUNERAL HOME <i>John Doe</i>	
58. NAME OF UNDERTAKER <i>John Doe</i>		59. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		60. NAME OF FUNERAL HOME <i>John Doe</i>	
61. NAME OF MINISTER <i>John Doe</i>		62. NAME OF CHURCH <i>St. Mary's Church</i>		63. NAME OF FUNERAL HOME <i>John Doe</i>	
64. NAME OF UNDERTAKER <i>John Doe</i>		65. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		66. NAME OF FUNERAL HOME <i>John Doe</i>	
67. NAME OF MINISTER <i>John Doe</i>		68. NAME OF CHURCH <i>St. Mary's Church</i>		69. NAME OF FUNERAL HOME <i>John Doe</i>	
70. NAME OF UNDERTAKER <i>John Doe</i>		71. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		72. NAME OF FUNERAL HOME <i>John Doe</i>	
73. NAME OF MINISTER <i>John Doe</i>		74. NAME OF CHURCH <i>St. Mary's Church</i>		75. NAME OF FUNERAL HOME <i>John Doe</i>	
76. NAME OF UNDERTAKER <i>John Doe</i>		77. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		78. NAME OF FUNERAL HOME <i>John Doe</i>	
79. NAME OF MINISTER <i>John Doe</i>		80. NAME OF CHURCH <i>St. Mary's Church</i>		81. NAME OF FUNERAL HOME <i>John Doe</i>	
82. NAME OF UNDERTAKER <i>John Doe</i>		83. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		84. NAME OF FUNERAL HOME <i>John Doe</i>	
85. NAME OF MINISTER <i>John Doe</i>		86. NAME OF CHURCH <i>St. Mary's Church</i>		87. NAME OF FUNERAL HOME <i>John Doe</i>	
88. NAME OF UNDERTAKER <i>John Doe</i>		89. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		90. NAME OF FUNERAL HOME <i>John Doe</i>	
91. NAME OF MINISTER <i>John Doe</i>		92. NAME OF CHURCH <i>St. Mary's Church</i>		93. NAME OF FUNERAL HOME <i>John Doe</i>	
94. NAME OF UNDERTAKER <i>John Doe</i>		95. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		96. NAME OF FUNERAL HOME <i>John Doe</i>	
97. NAME OF MINISTER <i>John Doe</i>		98. NAME OF CHURCH <i>St. Mary's Church</i>		99. NAME OF FUNERAL HOME <i>John Doe</i>	
100. NAME OF UNDERTAKER <i>John Doe</i>		101. NAME OF CEMETERY <i>St. Mary's Cemetery</i>		102. NAME OF FUNERAL HOME <i>John Doe</i>	

RECEIVED
APR 3 1945
BUREAU V. S.

2404 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital			d. STREET ADDRESS 400 Decatur St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Malda Middle Montra Last Showalter			4. DATE OF DEATH Month 3/29/57 Day 19 Year 19		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1918		9. AGE (In years last birthday) 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Elmer Mountain			14. MOTHER'S MAIDEN NAME Barbara Bowman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-9469		17. INFORMANT Patient's chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma ovaries 175x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinomatosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1yr. 3 mos. and 2 days 3 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 15, 1951 to Mar. 28 , 19 57 , that I last saw the deceased alive on Mar. 28 , 19 57 , and that death occurred at 3:10am , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 105 S. Centre St., Cumberland, Md. DATE SIGNED					
ACTUAL SIGNATURE C.C. Zimmermann		M.D. 105 S. Centre St., Cumberland, Md.			
PHYSICIAN'S NAME (Type) C.C. Zimmermann, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/57		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery Cumberland, Md.	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 29, 1957 W.K. Frantz, M.D.	
24b. REGISTRAR'S SIGNATURE					

CERTIFICATE OF DEATH

STANDARD & STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Name of Deceased [Illegible]		Date of Birth [Illegible]	
Sex [Illegible]		Race [Illegible]	
Usual Residence [Illegible]		Date of Death [Illegible]	
Cause of Death [Illegible]		Place of Death [Illegible]	
Signature of Physician [Illegible]		Signature of Registrar [Illegible]	
Date of Report [Illegible]		Office of Registrar [Illegible]	

BUREAU V. S.

APR 1 1933

RECEIVED

Name of Registrar [Illegible]		Title of Registrar [Illegible]	
Date of Report [Illegible]		Office of Registrar [Illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02444

2441 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midlothian				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midlothian			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUIS Middle SKIDMORE Last				4. DATE OF DEATH Month March Day 10 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-17-1884	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired miner				10b. KIND OF BUSINESS OR INDUSTRY coal mines		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Matthew Skidmore				14. MOTHER'S MAIDEN NAME Jane Bone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Nellie Skidmore, Midlothian, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic-hypertensive C-V dis. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 36 hrs + 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/9 , 19 57 , to 3/12 , 19 57 , that I last saw the deceased alive on 3/9 , 19 57 , and that death occurred at 3 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 26 Mechanics St. Frostburg, Md. DATE SIGNED 3/12/57							
ACTUAL SIGNATURE Frank T. Harrat M.D.				PHYSICIAN'S NAME (Type) FRANK T. HARRAT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-1957		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR 3-12-57	
				24b. REGISTRAR'S SIGNATURE Nancy N. Rose			

BUREAU V. S.

MAR 18 1957

RECEIVED

Within corporate limits

2405 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY Hardy			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOOREFIELD 85x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Baby Boy SMITH				4. DATE OF DEATH Month MARCH Day 5 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 3, 1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALVIN W. SMITH				14. MOTHER'S MAIDEN NAME ALFREDA V. HELMICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Memorial Hosp. Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 761.5 DUE TO Premature separation of placenta. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Placenta. (c) Placenta.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Mar 3, 1957 , to Mar 5, 1957 , that I last saw the deceased alive on Mar 5, 1957 , and that death occurred at 9:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Royce Hodges				ADDRESS (Street, city or town, state) Cumberland, Md. 3-6-57			
DATE SIGNED							
PHYSICIAN'S NAME (Type) W. ROYCE HODGES							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		March 6, 1957		Abie's Cem.		Redkey W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Steir Inc. Cumb.				ADDRESS MD 2		24a. REC'D BY REGISTRAR March 6, 1957	
				24b. REGISTRAR'S SIGNATURE W. Hantz, M.D.			

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresaptown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Cumberland, rural</u> x2.	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>Box 334 A</u> <u>R.F.D.#5 Winchester Road.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 220</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Shirley</u> Middle <u>Jean</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11-1930</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat packer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Swift & Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Arlie J. Martin</u>	
14. MOTHER'S MAIDEN NAME <u>Mildred Hirshman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>215-26-9940</u>		17. INFORMANT <u>James F. Smith, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broken neck (fractured cervical vertebrae)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Road slippery, ran off road and hit a tree, thrown out.</u>	
20c. TIME OF INJURY Month, Day, Year <u>7</u> Hour <u>o. m.</u> <u>3-1</u> <u>1957</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 220 near Cresaptown</u>	20f. (City or town) (County) (State) <u>Allegany Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 1-1957</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 4, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>March 2, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>W. R. Harty M.D.</u>

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2406

CERTIFICATE OF DEATH

02447

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Ridgeley, rural 85X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgeley, rural 85X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>Rt. #1</u>	
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>F.</u> Last <u>Sporkey</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-90</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>W. MD. Railroad</u>	
11c. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Deceased Paul Sporkey</u>		14. MOTHER'S MAIDEN NAME <u>Deceased Helen Olm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Patient's chart</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X cerebral hemorrhage</u> DUE TO (b) <u>hypertensive arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>January 19, 1957</u> to <u>March 18, 1957</u> that I last saw the deceased alive on <u>March 15, 1957</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. M. Schindler</u> M.D.		DATE SIGNED <u>March 20, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Blaise M. Schindler M.D.</u>		ADDRESS (Street, city or town, State) <u> </u>	
22a. BURIAL, CREMATION, REMAINS (Specify) <u> </u>		22b. DATE THEREOF <u>Mar. 23, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Acres of Rest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Escanaba, Michigan</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>	

BUREAU V. S.

MAR 22 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

DR. W.F. WLMS - MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18										02448	
2407 CERTIFICATE OF DEATH										Reg. Dist. No. 4	
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.			c. LENGTH OF STAY IN 1b 47 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL					d. STREET ADDRESS 1 8 PEAR ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PAULINE Middle MARY Last SWEITZER					4. DATE OF DEATH Month MARCH Day 25 Year 19 57						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-25-1891		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MD. Eckhart Mines			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George BOLLINGER					14. MOTHER'S MAIDEN NAME Josephine Felchlin						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio vascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes Mellitus</u>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7:28, 1949 to 3:25, 1957, that I last saw the deceased alive on 3:24, 1957, and that death occurred at 1:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W.F. Williams M.D. Cumberland Md 3/25/57											
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 3/27/57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery			22d. LOCATION (City, town, or county) (State) Cumberland Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland						ADDRESS DATE REC'D BY REGISTRAR March 28, 1957		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.			

CERTIFICATE OF DEATH

Y

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MAR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2498 CERTIFICATE OF DEATH

Reg. Dist. No.

02449

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 6 HRS.30 MIN.			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First TAYLOR Middle GARFIELD Last SWEITZER				4. DATE OF DEATH Month MARCH Day 27 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 9, 1882	
9. AGE (In years last birthday) 75 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Buchanan Lumber Little Orleans Md.		11. BIRTHPLACE (State or foreign country) U. S. A	
13. FATHER'S NAME JOHN HENRY SWEITZER				14. MOTHER'S MAIDEN NAME CHARLOTTE KEAR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-05-7645			
17. INFORMANT John H. Sweitzer				Address Cumberland Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Hypertensive Cardia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Renal Disease DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH First seen Feb. 74			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 2:17 , 19 44 , to 3:27 , 19 57 , that I last saw the deceased alive on 2:27 , 19 57 , and that death occurred at 3:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 3-28-57			
PHYSICIAN'S NAME (Type) W. F. Williams, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Bur. Park		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hager				ADDRESS Cumberland, Md			
24a. REC'D BY REGISTRAR March 30, 1957				24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02450

CERTIFICATE OF DEATH

2443

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Moscow		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Moscow			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) George (Middle) W. (Last) Thomas				(Month) March (Day) 22 (Year) 19 57			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH March 8, 1894	9. AGE last birthday 63 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Burriergard Thomas				14. MOTHER'S MAIDEN NAME Fouch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) yes		16. SOCIAL SECURITY NO. 1st W.W. 220-10-1758		17. INFORMANT & ADDRESS James Thomas Midlothian, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION "Son"		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) Coronary Occlusion							
ANTECEDENT CAUSE(S) DUE TO (B) Coronary Insufficiency +							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerosis							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 11 A.M. from the causes and on the date stated above.							
SIGNATURE Leslie R. Miles				ADDRESS (Street, city, town, state) Lonaconing Md		DATE SIGNED 3-22-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/25/57		NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		LOCATION (City, town, or county) (State) Moscow, Md.	
24. REC'D BY REGISTRAR DATE 3/25/57		REGISTRAR'S SIGNATURE Jannette M. Pool		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. RACE

5. DATE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. DATE OF BIRTH

14. PLACE OF BIRTH

15. SEX

16. RACE

17. DATE OF DEATH

18. PLACE OF DEATH

19. CAUSE OF DEATH

20. MANNER OF DEATH

21. SIGNATURE OF REGISTRAR

22. SIGNATURE OF DECEASED

23. SIGNATURE OF WITNESSES

24. DATE OF BIRTH

25. PLACE OF BIRTH

26. SEX

27. RACE

28. DATE OF DEATH

29. PLACE OF DEATH

30. CAUSE OF DEATH

31. MANNER OF DEATH

32. SIGNATURE OF REGISTRAR

33. SIGNATURE OF DECEASED

34. SIGNATURE OF WITNESSES

35. DATE OF BIRTH

36. PLACE OF BIRTH

37. SEX

38. RACE

39. DATE OF DEATH

40. PLACE OF DEATH

41. CAUSE OF DEATH

42. MANNER OF DEATH

43. SIGNATURE OF REGISTRAR

44. SIGNATURE OF DECEASED

45. SIGNATURE OF WITNESSES

46. DATE OF BIRTH

47. PLACE OF BIRTH

48. SEX

49. RACE

50. DATE OF DEATH

51. PLACE OF DEATH

52. CAUSE OF DEATH

53. MANNER OF DEATH

54. SIGNATURE OF REGISTRAR

55. SIGNATURE OF DECEASED

56. SIGNATURE OF WITNESSES

57. DATE OF BIRTH

58. PLACE OF BIRTH

59. SEX

60. RACE

61. DATE OF DEATH

62. PLACE OF DEATH

63. CAUSE OF DEATH

64. MANNER OF DEATH

65. SIGNATURE OF REGISTRAR

66. SIGNATURE OF DECEASED

67. SIGNATURE OF WITNESSES

68. DATE OF BIRTH

69. PLACE OF BIRTH

70. SEX

71. RACE

72. DATE OF DEATH

73. PLACE OF DEATH

74. CAUSE OF DEATH

75. MANNER OF DEATH

76. SIGNATURE OF REGISTRAR

77. SIGNATURE OF DECEASED

78. SIGNATURE OF WITNESSES

79. DATE OF BIRTH

80. PLACE OF BIRTH

81. SEX

82. RACE

83. DATE OF DEATH

84. PLACE OF DEATH

85. CAUSE OF DEATH

86. MANNER OF DEATH

87. SIGNATURE OF REGISTRAR

88. SIGNATURE OF DECEASED

89. SIGNATURE OF WITNESSES

90. DATE OF BIRTH

91. PLACE OF BIRTH

92. SEX

93. RACE

94. DATE OF DEATH

95. PLACE OF DEATH

96. CAUSE OF DEATH

97. MANNER OF DEATH

98. SIGNATURE OF REGISTRAR

99. SIGNATURE OF DECEASED

100. SIGNATURE OF WITNESSES

101. DATE OF BIRTH

102. PLACE OF BIRTH

103. SEX

104. RACE

105. DATE OF DEATH

106. PLACE OF DEATH

107. CAUSE OF DEATH

108. MANNER OF DEATH

109. SIGNATURE OF REGISTRAR

110. SIGNATURE OF DECEASED

111. SIGNATURE OF WITNESSES

112. DATE OF BIRTH

113. PLACE OF BIRTH

114. SEX

115. RACE

116. DATE OF DEATH

117. PLACE OF DEATH

118. CAUSE OF DEATH

119. MANNER OF DEATH

120. SIGNATURE OF REGISTRAR

121. SIGNATURE OF DECEASED

122. SIGNATURE OF WITNESSES

123. DATE OF BIRTH

124. PLACE OF BIRTH

125. SEX

126. RACE

127. DATE OF DEATH

128. PLACE OF DEATH

129. CAUSE OF DEATH

130. MANNER OF DEATH

131. SIGNATURE OF REGISTRAR

132. SIGNATURE OF DECEASED

133. SIGNATURE OF WITNESSES

134. DATE OF BIRTH

135. PLACE OF BIRTH

136. SEX

137. RACE

138. DATE OF DEATH

139. PLACE OF DEATH

140. CAUSE OF DEATH

141. MANNER OF DEATH

142. SIGNATURE OF REGISTRAR

143. SIGNATURE OF DECEASED

144. SIGNATURE OF WITNESSES

145. DATE OF BIRTH

146. PLACE OF BIRTH

147. SEX

148. RACE

149. DATE OF DEATH

150. PLACE OF DEATH

151. CAUSE OF DEATH

152. MANNER OF DEATH

153. SIGNATURE OF REGISTRAR

154. SIGNATURE OF DECEASED

155. SIGNATURE OF WITNESSES

156. DATE OF BIRTH

157. PLACE OF BIRTH

158. SEX

159. RACE

160. DATE OF DEATH

161. PLACE OF DEATH

162. CAUSE OF DEATH

163. MANNER OF DEATH

164. SIGNATURE OF REGISTRAR

165. SIGNATURE OF DECEASED

166. SIGNATURE OF WITNESSES

167. DATE OF BIRTH

168. PLACE OF BIRTH

169. SEX

170. RACE

171. DATE OF DEATH

172. PLACE OF DEATH

173. CAUSE OF DEATH

174. MANNER OF DEATH

175. SIGNATURE OF REGISTRAR

176. SIGNATURE OF DECEASED

177. SIGNATURE OF WITNESSES

178. DATE OF BIRTH

179. PLACE OF BIRTH

180. SEX

181. RACE

182. DATE OF DEATH

183. PLACE OF DEATH

184. CAUSE OF DEATH

185. MANNER OF DEATH

186. SIGNATURE OF REGISTRAR

187. SIGNATURE OF DECEASED

188. SIGNATURE OF WITNESSES

189. DATE OF BIRTH

190. PLACE OF BIRTH

191. SEX

192. RACE

193. DATE OF DEATH

194. PLACE OF DEATH

195. CAUSE OF DEATH

196. MANNER OF DEATH

197. SIGNATURE OF REGISTRAR

198. SIGNATURE OF DECEASED

199. SIGNATURE OF WITNESSES

200. DATE OF BIRTH

201. PLACE OF BIRTH

202. SEX

203. RACE

204. DATE OF DEATH

205. PLACE OF DEATH

206. CAUSE OF DEATH

207. MANNER OF DEATH

208. SIGNATURE OF REGISTRAR

209. SIGNATURE OF DECEASED

210. SIGNATURE OF WITNESSES

211. DATE OF BIRTH

212. PLACE OF BIRTH

213. SEX

214. RACE

215. DATE OF DEATH

216. PLACE OF DEATH

217. CAUSE OF DEATH

218. MANNER OF DEATH

219. SIGNATURE OF REGISTRAR

220. SIGNATURE OF DECEASED

221. SIGNATURE OF WITNESSES

222. DATE OF BIRTH

223. PLACE OF BIRTH

224. SEX

225. RACE

226. DATE OF DEATH

227. PLACE OF DEATH

228. CAUSE OF DEATH

229. MANNER OF DEATH

230. SIGNATURE OF REGISTRAR

231. SIGNATURE OF DECEASED

232. SIGNATURE OF WITNESSES

233. DATE OF BIRTH

234. PLACE OF BIRTH

235. SEX

236. RACE

237. DATE OF DEATH

238. PLACE OF DEATH

239. CAUSE OF DEATH

240. MANNER OF DEATH

241. SIGNATURE OF REGISTRAR

242. SIGNATURE OF DECEASED

243. SIGNATURE OF WITNESSES

244. DATE OF BIRTH

245. PLACE OF BIRTH

246. SEX

247. RACE

248. DATE OF DEATH

249. PLACE OF DEATH

250. CAUSE OF DEATH

251. MANNER OF DEATH

252. SIGNATURE OF REGISTRAR

253. SIGNATURE OF DECEASED

254. SIGNATURE OF WITNESSES

255. DATE OF BIRTH

256. PLACE OF BIRTH

257. SEX

258. RACE

259. DATE OF DEATH

260. PLACE OF DEATH

261. CAUSE OF DEATH

262. MANNER OF DEATH

263. SIGNATURE OF REGISTRAR

264. SIGNATURE OF DECEASED

265. SIGNATURE OF WITNESSES

266. DATE OF BIRTH

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 days 6 1/2 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) Sacred Heart H ospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Alice Last Turner		4. DATE OF DEATH Month 3 Day 26 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1877
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR: Months 19 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Corn Rone		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) West End Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Mowery		14. MOTHER'S MAIDEN NAME Margaret Lafferty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Alvia C. Turner, Cumb. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral Arteriosclerosis cause (c), stating the underlying cause lost. (c) Essential Hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death 48 hours unknown unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/23 , 19 57 , to 3/26 , 19 57 , that I last saw the deceased alive on 3/25 , 19 57 , and that death occurred at 7:56 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE S. G. WEISMAN M.D.		ADDRESS (Street, city or town, state) 59 Greene St DATE SIGNED 3/26/57	
PHYSICIAN'S NAME (Type) S. G. WEISMAN MD Cumberland, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 29, 1957	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS Cumb. Md.	
24a. REC'D BY REGISTRAR March 28, 1957		24b. REGISTRAR'S SIGNATURE W. R. Parry, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. S.

MAR 29 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2410 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b _____	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		e. STREET ADDRESS <u>5240 York Rd.</u> <u>3001.4</u>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>N.</u> Last <u>Weber</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12-1873</u>
9. AGE (in years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Herkman Weber</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Kolb</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>(son) Harry Weber, Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrathoracic hemorrhage</u> DUE TO (b) <u>Crushed chest(left)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>Auto accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto ran into rear end of tractor trailer.</u>	
20c. TIME OF INJURY Month, Day, Year <u>10.30 a.m. March 19/57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway Rt. 40 near Flintstone, Allegany, Md</u>	20f. (City or town) (County) (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 19-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-23-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Randalstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>March 21, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>M.R. Frank M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
 STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Doe		Male		45		White		March 20, 1957		Home	
Occupation		Cause of Death		Manner of Death		Signature of Examiner		Signature of Physician		Signature of Coroner	
Teacher		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
Residence		Date of Burial		Place of Burial		Signature of Burial Officer		Signature of Minister		Signature of Undertaker	
123 Main St.		March 22, 1957		St. Mary's Church		[Signature]		[Signature]		[Signature]	
City		County		State		Filing Date		Filing Time		Filing Office	
Baltimore		Anne Arundel		Maryland		March 22, 1957		10:00 AM		State Office	

BUREAU V. S.

MAR 22 1957

RECEIVED

ORIGINAL FILED IN

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2411 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02453/4
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 8 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 135 N.Mechanic St. Southern Hotel				d. STREET ADDRESS 135 N.Mechanic St. Hotel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Gibson Last Willison				4. DATE OF DEATH Month March Day 27 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 11-1911	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender & Cook		10b. KIND OF BUSINESS OR INDUSTRY Hi-Dee Bar		11. BIRTHPLACE (State or foreign country) Fort Ashby, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harvey Willison				14. MOTHER'S MAIDEN NAME Susan Pyles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.2 705-12-0889		17. INFORMANT (sister) Pearl Brant, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c) ?						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		March 27-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 30, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		22d. LOCATION (City, town, or county) (State) Fort Ashby, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Service, Cumberland, Maryland.				ADDRESS March 28, 1957		24a. REC'D BY REGISTRAR W.R. Brant, M.D.	
				24b. REGISTRAR'S SIGNATURE			

2412 CERTIFICATE OF DEATH

02454

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 40 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 441 CUMBERLAND STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First A Middle FLORIAN Last WILSON		4. DATE OF DEATH Month MARCH Day 26 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/27/93
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUSINESS MGR.		10b. KIND OF BUSINESS OR INDUSTRY ST. TEACHERS COLLEGE MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT WILSON		14. MOTHER'S MAIDEN NAME IDA SPRIGGS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 214 05 7468	
17. INFORMANT MEMORIAL HOSPITAL—MEMORIAL & WARWICK AVES.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10.16.1956 to 3-25-1957 , that I last saw the deceased alive on 3.25.1957 , and that death occurred at 12:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. F. Williams		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 3/26/57	
PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/29/1957	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William H. Right, Cumberland, Md.		24a. REC'D BY REGISTRAR March 28, 1957 24b. REGISTRAR'S SIGNATURE W.R. Franky, M.D.	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED WILLSON, EDWARD</p>		<p>2. SEX M</p>		<p>3. AGE 36</p>	
<p>4. DATE OF DEATH 1957</p>		<p>5. PLACE OF DEATH ST. LOUIS, MO.</p>		<p>6. CAUSE OF DEATH HEART DISEASE</p>	
<p>7. OCCUPATION ENGINEER</p>		<p>8. MARITAL STATUS MARRIED</p>		<p>9. PLACE OF BIRTH ST. LOUIS, MO.</p>	
<p>10. DATE OF BIRTH 1921</p>		<p>11. PLACE OF BIRTH ST. LOUIS, MO.</p>		<p>12. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>13. SIGNATURE OF WITNESSES J. H. WILSON</p>		<p>14. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>15. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>16. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>17. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>18. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>19. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>20. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>21. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>22. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>23. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>24. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>25. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>26. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>27. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>28. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>29. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>30. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>31. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>32. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>33. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>34. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>35. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>36. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>37. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>38. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>39. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>40. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>41. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>42. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>43. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>44. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>45. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>46. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>47. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>48. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>49. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>50. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>51. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>52. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>53. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>54. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>55. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>56. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>57. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>58. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>59. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>60. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>61. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>62. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>63. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>64. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>65. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>66. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>67. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>68. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>69. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>70. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>71. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>72. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>73. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>74. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>75. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>76. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>77. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>78. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>79. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>80. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>81. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>82. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>83. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>84. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>85. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>86. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>87. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>88. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>89. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>90. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>91. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>92. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>93. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>94. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>95. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>96. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>97. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>98. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>99. SIGNATURE OF DECEASED EDWARD WILLSON</p>	
<p>100. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>101. SIGNATURE OF DECEASED EDWARD WILLSON</p>		<p>102. SIGNATURE OF DECEASED EDWARD WILLSON</p>	

BUREAU V. S.

MAR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2431 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 113 Centenial St.				d. STREET ADDRESS 113 Centenial St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Margaret Middle Brode Last Winner				4. DATE OF DEATH Month March Day 21 Year 19 57				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15-1887		
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Brode				14. MOTHER'S MAIDEN NAME Althea Hensel				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT (son) Raymond Winner, Frostburg, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH sudden ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE H.V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER March 21-1957				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 3-23-57		
				24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Poe				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 12 Film G213 4-8-57 et
2413 CERTIFICATE OF DEATH

Reg. Dist. No.

02456

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penn. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 35 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DOMINIC Middle JOHN Last VOYTOVICH WOJCIK		4. DATE OF DEATH Month 3 Day 27 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-81
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wojcik		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 191-07-5815	
17. INFORMANT Ted WOJCIK		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thromboses DUE TO (c) Arteriosclerotic Cardio Vascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Constrictive Heart Failure 1 1/2 months			
INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days 2 1/2 to 10 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 4, 1957 to 3/27 , 19 57 , that I last saw the deceased alive on 3/26 , 19 57 , and that death occurred at 7:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3/29/57 DATE SIGNED			
ACTUAL SIGNATURE Homeism		M.D.	
PHYSICIAN'S NAME (Type) S. G. WEISMAN, M.D.		59 GREEN ST. CUMBERLAND, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/1/57	22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cem.	22d. LOCATION (City, town, or county) (State) Footedale, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Yoney Funeral Home		ADDRESS Masontown, Pa.	
24a. REC'D BY REGISTRAR March 29, 1957		24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be deposited for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH 191-07-3011

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BUREAU V. S.

APR 1 1957

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